No. 91-2079-CFX
Status: GRANTED

Title: Good Samaritan Hospital, et al., Petitioners
v.
Donna E. Shalala, Secretary of Health and Human Services

Docketed:
June 26, 1992

Court: United States Court of Appeals for the Eighth Circuit

Counsel for petitioner: Hedlund,Carel T.

Counsel for respondent: Solicitor General

Time to file ext by J. Blackmun to & inc July 6, 1992. CITED

Entry	Date	Note	Proceedings and Orders
1	Apr 23 1992	G	Application (A91-782) to extend the time to file a petition for a writ of certiorari from May 7, 1992 to July 6, 1992, submitted to Justice Blackmun.
3	Apr 23 1992		Application for extension of time to file petition and order granting same until July 6, 1992 (Blackmun, April 28, 1992).
2	Apr 28 1992		Application (A91-782) granted by Justice Blackmun extending the time to file until July 6, 1992.
4	Jun 26 1992	G	Petition for writ of certiorari filed.
6	Jul 27 1992		Order extending time to file response to petition until August 28, 1992.
7	Aug 27 1992		Order further extending time to file response to petition until September 11, 1992.
9	Sep 11 1992		Brief of respondent Louis W. Sullivan, M.D., Sec., H&HS filed.
8	Sep 16 1992		DISTRIBUTED. October 9, 1992
10	Oct 13 1992		Petition GRANTED.
			**********
11	Nov 23 1992		Record filed.
		*	Partial proceedings United States Court of Appeals for the Eighth Circuit.
12	Nov 25 1992		Brief amicus curiae of American Health Care Association filed.
13	Nov 25 1992		Joint appendix filed.
14	Nov 25 1992		Brief of petitioners Good Samaritan Hospital, et al. filed.
15	Dec 3 1992		Record filed.
		*	Original proceedings United States District Court for the District of Nebraska (Box)
16	Dec 30 1992		Brief of respondent Louis W. Sullivan, Secretary HHS filed.
17	Feb 2 1993		Reply brief of petitioners filed.
19	Feb 4 1993		CIRCULATED.
18	Mar 3 1993		SET FOR ARGUMENT MONDAY, MARCH 22, 1993. (2ND CASE).
20	Mar 22 1993		ARGUED.

91-2079

No. _____

Supreme Court, U.S.
FILED
JUN 26 1992
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, THE MARY LANNING MEMORIAL HOSPITAL ASSOCIATION, MEMORIAL COMMUNITY HOSPITAL, INC., MEMORIAL HOSPITAL OF DODGE COUNTY, MEMORIAL HOSPITAL AND ST. MARY'S HOSPITAL, PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

Under the Medicare statute for the years under appeal, hospitals were reimbursed for their "reasonable cost" of providing services to Medicare patients. The statute permits the use of "cost limits" based on estimates as one of the methods of determining reasonable cost.

The Medicare statute also provides that the Secretary must provide for "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) ("clause (ii)"). The Supreme Court in *Bowen v. Georgetown University Hospital,* 488 U.S. 204, 210 (1988), held that clause (ii) requires "case-by-case inquiry into the accuracy of reimbursement determinations for individual providers," and does not authorize retroactive rulemaking by the Secretary to change the methods of reimbursement.

The questions presented for review are:

1. Are the case-by-case adjustments required under clause (ii) limited to year-end book-balancing to reconcile interim payments received during the year with the amounts due under the regulatory methods for determining reasonable cost, as the Eighth and D.C. Circuits have held, or must they include substantive adjustments to an individual provider's reimbursement when the regulatory methods themselves result in inadequate or excessive reimbursement, as the Ninth Circuit has held.

A necessary subquestion is whether the Secretary's cost limit regulation at 42 C.F.R. § 413.30, which permits Medicare providers to obtain only narrow exceptions to the cost limits, is consistent with clause (ii) where it does not provide any mechanism for relief for providers which receive inadequate reimbursement due to an admitted flaw in the cost limits methodology.

2. Does *Georgetown's* prohibition against retroactive rulemaking extend to preclude relief to an individual provider under clause (ii) through the remedy granted to Medicare providers by Congress under 42 U.S.C. § 1395oo for case-by-case adjudications if the relief sought would have constituted retroactive rulemaking had the Secretary made the relief applicable to all providers through rulemaking.

RULE 29.1 LIST

The parent company of Good Samaritan Hospital is Good Samaritan Health Systems, Inc. The parent company of Memorial Community Hospital, Inc. is Memorial Community Health System, Inc. The parent company of St. Mary's Hospital is St. Elizabeth Health System.

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No. _____

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, THE MARY LANNING MEMORIAL HOSPITAL ASSOCIATION, MEMORIAL COMMUNITY HOSPITAL, INC., MEMORIAL HOSPITAL OF DODGE COUNTY, MEMORIAL HOSPITAL AND ST. MARY'S HOSPITAL, PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

The Petitioners, Good Samaritan Hospital, The Mary Lanning Memorial Hospital Association, Memorial Community Hospital, Inc., Memorial Hospital of Dodge County, Memorial Hospital and St. Mary's Hospital, respectfully pray that a Writ of Certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, entered in the above proceeding on December 30, 1991.

OPINIONS BELOW

The opinion of the Court of Appeals for the Eighth Circuit is reported at 952 F.2d 1017 (8th Cir. 1991), and is reprinted in the Appendix at 1a. The Memorandum Deci-

sion of the United States District Court for the District of Nebraska (Urbom, D.J.) is reported at [1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,400 (D. Neb. Feb. 16, 1990), and is reprinted in the Appendix at 19a. The decisions of the Provider Reimbursement Review Board are reprinted in the Appendix beginning at 37a.

JURISDICTION

The final judgment of the United States Court of Appeals for the Eighth Circuit was issued and entered on December 30, 1991. The Petitioners filed a Petition for Rehearing and Suggestion for Rehearing En Banc on January 11, 1992. The Order denying both the Petition for Rehearing and Suggestion for Rehearing En Banc was entered on February 7, 1992. (Appendix at 18a.) On April 28, 1992 this Court granted the Petitioners' application for an extension of time to file the Petition for Certiorari until July 6, 1992.

The jurisdiction of this Court to review the judgment of the Eighth Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Petitioners assert that the Secretary of Health and Human Services ("Secretary") violated 42 U.S.C. § 1395x(v)(1)(A)(ii), the provision of the Medicare Act which directs the Secretary to make a suitable retroactive corrective adjustment to a Medicare provider when the Secretary's chosen methods of cost calculation result in inadequate reimbursement of an individual provider's reasonable cost. The text of 42 U.S.C. § 1395x(v)(1)(A) is reprinted in full in the Appendix at 72a.

STATEMENT OF THE CASE

The Petitioners are rural Nebraska hospitals which are providers of inpatient hospital services to Medicare beneficiaries, pursuant to "Provider Agreements" with the Secretary. For the cost reporting periods under appeal in this case, the Medicare statute required the Secretary to reimburse providers the lower of the "reasonable costs" of furnishing covered services to Medicare beneficiaries or the customary charge for such services. 42 U.S.C. § 1395f(b). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A).

The Medicare statute directs the Secretary to establish a method or methods for calculating "reasonable costs." *Id.* However, the statute also provides that when the Secretary's methods result in reimbursement to an individual provider that "proves to be either inadequate or excessive" to reimburse that provider's actual reasonable cost, the Secretary is required to make a "suitable retroactive corrective adjustment" to the reimbursement for that provider. 42 U.S.C. § 1395x(v)(1)(A)(ii) (hereafter "clause (ii)".)

One of the methods of determining reasonable cost permitted by the statute is a schedule "of limits on the direct or indirect overall incurred costs or incurred cost of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services. . . ." *Id.* Pursuant to this statutory authority, the Secretary has published annual schedules of "cost limits." The legislative history accompanying the authority to establish the cost limits indicates that they were to be applied on a presumptive basis and that providers would have the right "to obtain relief from the effect of the cost limit on the basis of

evidence of the need for such an exemption." S. Rep. No. 92-1230, 92nd Cong., 2nd Sess. 187-189 (1972).

The Secretary's cost limit methodology for the years at issue here classified hospitals as urban (i.e., located in a Standard Metropolitan Statistical Area ("SMSA")) or rural (i.e., not in a SMSA), and used a wage index for the provider's geographic location to determine the labor-related component of a provider's costs. The data used to develop the wage index was from the Bureau of Labor Statistics ("BLS"). This BLS data did not distinguish between part-time and full-time employees. The result, admitted by the Secretary, is that the wage index was distorted downward for those areas that had a high proportion of part-time employees.

The Secretary has promulgated regulations under which providers may request a reclassification, exemption or exception from the cost limits. 42 C.F.R. § 405.460(d)-(f) (1975), *recodified as* 42 C.F.R. § 413.30(d)-(f) (1991). However, as the parties below agreed, none of these provisions permit any relief from the cost limits where providers exceed the cost limits due to the failure of the cost limits methodology to account for the use of part-time employees. The Secretary's position in this and other cases is that unless a provider's claim for relief qualifies as one of the exemptions or exceptions set forth in the regulation, no relief is available in the form of a retroactive corrective adjustment when the reimbursement proves to be inadequate.

Each of the Petitioners is classified as a rural Nebraska hospital for Medicare purposes. Hospitals in rural Nebraska as a whole, and each petitioner individually, employs a high percentage of part-time employees. As a result, each of the Petitioners exceeded the rural Nebraska Medicare cost limits in the years under appeal (FYs 1980-1983). Pursuant to 42 U.S.C. § 1395oo, each of the Petitioners filed an appeal to the Provider Reimbursement Review Board ("PRRB") for the years in which they exceeded the cost limits.

The Hospitals contended in their appeals that their costs in excess of the cost limits were nonetheless reasonable. They challenged the fact that the Medicare cost limits (1) did not account for the use of part-time employees, (2) did not permit rural hospitals to show they incurred similar costs as urban hospitals, and (3) were applied in a conclusive rather than a presumptive fashion, because there was no regulatory exceptions mechanism available by which the providers could obtain relief from the limits for these problems. They therefore claimed they were entitled to a retroactive corrective adjustment under clause (ii). In addition, Petitioner Memorial Community Hospital also challenged the Secretary's denial of its request for reclassification from "rural" hospital status to "urban" hospital status.

The Board granted jurisdiction over the appeals of the six hospitals, for a total of twenty cost years. Because the Board is bound by the Secretary's regulations, including the cost limits methodology, it could not grant the Hospitals the relief they sought, i.e., reimbursement in excess of the cost limits. The Board therefore granted the Hospitals' request for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1), thereby allowing the hospitals to take their challenge directly into district court. (Appendix 37a-53a). The PRRB denied jurisdiction over the appeals of three of the cost years.[1]

On cross-motions for summary judgment, the district court ruled in favor of the Hospitals in that it held that the cost limits may be applied only on a presumptive rather than a conclusive basis. The court held that clause (ii) of § 1395x(v)(1)(A) required the Secretary to make retroactive

[1] The Board denied jurisdiction over St. Mary's Hospital for FY 1981, Memorial Hospital (Seward) for FY 1981 and Memorial Hospital of Dodge County for FY 1980 on the ground that the appeals for those years were not timely filed.

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adjustments to the Hospitals' reimbursement where the Secretary's cost limits method, even though valid, resulted in inadequate reimbursement of the Hospitals' reasonable costs. In so holding, the court relied on the prior decision of the Eighth Circuit in *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987). The district court rejected the Secretary's contention that *St. Paul-Ramsey* was no longer good law after the Supreme Court's decision in *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988) ("*Georgetown*"). Rather, the district court held that *St. Paul-Ramsey* was consistent with the *Georgetown* decision, which held that clause (ii) does not authorize retroactive rulemaking, but does require case-by-case adjustments for individual providers where the regulatory methods do not result in correct reimbursement.

The district court remanded the case to the Secretary "for a hearing from which he (1) shall apply to the cost years under appeal a wage index which takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-MSA designation of the plaintiffs in determining whether the aggregate reimbursement produced by the methods of determining costs has proved to be inadequate." With respect to Memorial Community Hospital, the district court held the Secretary's denial of its reclassification request was not arbitrary and capricious. The district court also affirmed the decision of the PRRB denying jurisdiction over three of the cost years.

The court of appeals reversed the district court's ruling that the hospitals were entitled to a suitable retroactive corrective adjustment where the cost limits regulation resulted in inadequate reimbursement, and held that its prior interpretation of clause (ii) in *St. Paul-Ramsey* had been overruled by the Supreme Court's decision in *Georgetown.* The Eighth Circuit read *Georgetown* as holding that the retroactive corrective adjustment required by clause (ii) is only

year-end "book-balancing" to reconcile the interim estimated payments a provider receives during the year with the amounts actually due for the year pursuant to the Secretary's methods of determining reasonable cost. It concluded that the kind of retroactive corrective adjustment sought by the Hospitals, which would reimburse costs in excess of the cost limits, would amount to retroactive rulemaking that *Georgetown* prohibited.

The court of appeals further held that the Secretary's cost limit methodology was valid and reasonable. Although the BLS data used for the wage index did not account for part-time employees, the court deferred to the Secretary's conclusion that it was the best data available. The court of appeals also affirmed the district court's ruling with respect to the reclassification of Memorial Community Hospital and PRRB jurisdiction over three of the years under appeal.[2]

REASONS FOR GRANTING THE WRIT

I. THE COURTS OF APPEALS DISAGREE AS TO THE PROPER INTERPRETATION OF THE SUITABLE RETROACTIVE CORRECTIVE ADJUSTMENT PROVISION IN CLAUSE (ii) AND THIS COURT'S DECISION IN *GEORGETOWN*

Prior to this Court's decision in *Georgetown,* the Eighth Circuit in *St. Paul-Ramsey* held that under clause (ii) the Secretary has a duty to make a suitable retroactive corrective adjustment to a provider's reimbursement whenever his methods of determining reasonable cost result in inadequate or excessive reimbursement. Other courts of appeals had similarly held that under clause (ii) the Secretary is required to make a retroactive adjustment when a provider receives

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[2] The Petitioners do not seek certiorari on the issues of the reclassification of Memorial Community Hospital and PRRB jurisdiction over the three cost years.

reimbursement that is less or greater than its actual, reasonable cost, as calculated under the cost limits or any other method for determining reasonable cost. *See Medical Center Hosp. v. Bowen,* 839 F.2d 1504 (11th Cir. 1988); *Regents of the Univ. of Cal. v. Heckler,* 771 F.2d 1182 (9th Cir. 1985); *Springdale Convalescent Center v. Mathews,* 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc. v. United States,* 536 F.2d 347 (Ct. Cl. 1976), *cert. denied,* 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center v. Richardson,* 486 F.2d 663 (2d Cir. 1973). Only one court had held that clause (ii) is limited to year-end book-balancing. *Daughters of Miriam Center for the Aged v. Mathews,* 590 F.2d 1250 (3d Cir. 1978).

In *Georgetown,* the Secretary argued that clause (ii) authorized him to engage in across-the-board retroactive rulemaking applicable to all providers. This Court unanimously rejected the Secretary's interpretation, holding that clause (ii) authorized only individual case-by-case adjustments, not retroactive rulemaking. "To the contrary, we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." 488 U.S. at 209. In declining to defer to the Secretary's interpretation that clause (ii) authorized retroactive rulemaking, the Court in *dicta* noted that in the past the Secretary had asserted that clause (ii) required only year-end book-balancing. 488 U.S. at 211 and n.2.[3]

[3] However, the Secretary has cited clause (ii) as authority for numerous other actions apart from year-end book-balancing or retroactive rulemaking. *See, e.g., Medical Center Hospital,* 839 F.2d at 1511 (Secretary argued clause (ii) is satisfied by cost limits exceptions process in 42 C.F.R. § 413.30); *Springdale Convalescent Center,* 545 F.2d at 954 (Secretary argued clause (ii) authorized regulation at 42 C.F.R. § 413.134(d)(3) (formerly § 405.415(d)(3)), which permits Medicare to recoup the difference between accelerated and straight-line depreciation for all years of participation in the Medicare program when a provider leaves the program); *St. James Hospital v. Heckler,* 760 F.2d 1460 (7th Cir. 1985), *cert. denied,* 474 U.S. 902 (1985) (Reply Brief for Appellant at 22-23) (Secretary argued that clause (ii) authorized the regulation at 42 C.F.R. § 405.1885 governing reopening of cost reports for prior periods).

Subsequent to the *Georgetown* decision, the D.C. Circuit in *Hennepin County v. Sullivan,* 883 F.2d 85 (D.C. Cir. 1989), *cert. denied,* 493 U.S. 1043 (1990), interpreted the *Georgetown* Court's observation regarding the Secretary's past position as a holding that clause (ii) only permits the Secretary to perform year-end book-balancing to adjust a provider's interim reimbursement with the amounts actually due under the regulations. The Eighth Circuit in the decision below similarly held that, according to *Georgetown,* clause (ii) only requires book-balancing.[4]

In contrast, the Ninth Circuit expressly rejected this interpretation of *Georgetown* in *Mt. Diablo Hospital v. Sullivan,* 5 Medicare and Medicaid Guide (CCH) ¶ 40,203 (9th Cir. April 28, 1992), *pet. for reh'g with a suggestion for reh'g in banc filed* June 11, 1992, a case which also involves a challenge to the cost limits for failure to account for part-time employees. (A copy of the Ninth Circuit decision is contained in the Appendix at 55a.) Instead, the Ninth Circuit held that *Georgetown* did not overrule its earlier decision in *Regents of the Univ. of California v. Heckler,*

[4] In *Sierra Medical Center v. Sullivan,* 902 F.2d 388 (5th Cir. 1990), the provider sought to have a change in a regulation applied retroactively to a prior cost year. The Fifth Circuit rejected the provider's argument, relying on *Georgetown's* prohibition on retroactive rulemaking. It is unclear whether the Fifth Circuit concluded that *Georgetown* overruled its prior decision in *Springdale Convalescent Center v. Mathews,* 545 F.2d 943 (5th Circuit 1977).

771 F.2d 1182 (9th Cir. 1985), which interpreted clause (ii) to require the Secretary to make a retroactive adjustment to reimburse a provider for all its "reasonable costs," even if those costs exceeded the cost limits and did not qualify for treatment as an exception or exemption under the Secretary's regulations.

The Ninth Circuit expressly disagreed with the conclusion of the Eighth Circuit, in *Good Samaritan,* that the kind of individual adjustment the hospitals were seeking amounted to a retroactive change in the cost limit methodology in violation of *Georgetown* and its prohibition on retroactive rulemaking. (Appendix at 70a.) The Ninth Circuit held, instead, that the hospitals were seeking only the very kind of case-by-case adjustment to their individual reimbursement that was sanctioned by this Court in *Georgetown.* The Ninth Circuit remanded the case to permit Mt. Diablo Hospital to demonstrate that its costs in excess of the cost limits were reasonable.

Thus, there is a clear and direct split among the Circuits concerning the duty imposed on the Secretary by clause (ii) and the proper interpretation of this Court's decision in *Georgetown.* In the Ninth Circuit, as well as in the Second and Eleventh Circuits and the Claims Court, clause (ii) continues to be interpreted to require substantive reimbursement adjustments to individual providers, not simply year-end book-balancing. In the Eighth and D.C. Circuits, the duty imposed by clause (ii) is limited to accounting reconciliations at the end of the year. The granting of this petition therefore is necessary to achieve uniform construction of the statutory language, to assist the Secretary in the administration of the Medicare program, and to ensure that all Medicare providers will understand what the statute means.

II. THE EIGHTH CIRCUIT'S INTERPRETATION OF CLAUSE (ii) TO DENY PETITIONERS A REMEDY FOR AN INDIVIDUAL ADJUSTMENT TO THEIR REIMBURSEMENT UNDER 42 U.S.C. § 1395oo IS IN CONFLICT WITH *GEORGETOWN.*

The Petitioners sought an individual adjustment to their reimbursement because the cost limits methodology was applied to them in a conclusive fashion, rather than in a presumptive manner, which resulted in inadequate reimbursement of their reasonable costs. The Eighth Circuit found that the Petitioners' claim amounted to retroactive rulemaking because, if the Petitioners succeeded in obtaining any reimbursement in excess of the cost limits methodology, the remedy would be tantamount to a retroactive change in the cost limits rules, which the court found was prohibited by *Georgetown.*

The Eighth Circuit's characterization of the remedy Petitioners' seek as retroactive rulemaking ignores the very dichotomy recognized in *Georgetown* between case-by-case adjudications resulting in adjustments to individual providers' reimbursement, which by nature are retroactive, and across-the-board rulemaking by the Secretary, which must be prospective. The only way the Hospitals can obtain the adjustments they seek to their reimbursement is through the appeals process in 42 U.S.C. § 1395oo, which requires that the appeals be brought on a retrospective basis following the close of the cost year under appeal. Certainly nothing in the *Georgetown* construction of clause (ii) even intimated that it intended to overrule the remedy given in § 1395oo(f), i.e., to permit providers to go to court to challenge the conclusive application of the cost limits and to obtain an individualized adjustment for reimbursement in excess of the cost limits. This is especially so since the authority to promulgate the cost limits was contained in the same legislation that created the remedy in § 1395oo. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 223,243(a).

III. THIS ISSUE INVOLVES THE REQUISITE PUBLIC IMPORTANCE TO MEDICARE PROVIDERS THROUGHOUT THE NATION

The interpretation of clause (ii) affects numerous Medicare providers throughout the country that are reimbursed on the basis of "reasonable cost." While, with the advent of the prospective payment system (PPS) beginning October 1, 1983, acute care hospitals are no longer reimbursed on the basis of reasonable cost, the Medicare cost limits remain applicable to skilled nursing facilities ("SNFs") and home health agencies ("HHAs"). Presently, there are 6,200 participating SNFs and 6,000 HHAs that are subject to the Secretary's cost limits. For those providers that exceed the cost limits and do not fall within one of the very narrow exceptions to the limits provided for by the Secretary, this issue remains of paramount importance.

CONCLUSION

For the foregoing reasons, this Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Nos. 90-1641/1642

GOOD SAMARITAN HOSPITAL, ETC., ET AL., APPELLANTS,

v.

LOUIS W. SULLIVAN, ETC., APPELLEE.

Appeals from the United States District Court for the District of Nebraska

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Submitted: December 12, 1990
Filed: December 30, 1991

Before MCMILLIAN and FAGG, Circuit Judges, and ARNOLD,* District Judge.

McMILLIAN, Circuit Judge.

Good Samaritan Hospital, Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, St. Mary's Hospital, and Mary Lanning Memorial Hospital (collectively appellants[1]) appeal from a

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* The Honorable Morris S. Arnold, United States District Judge for the Western District of Arkansas, sitting by designation.

[1] Mary Lanning Memorial Hospital is not a party appellant in this case because we hold that we lack appellate jurisdiction over it as discussed below. Mary Lanning Memorial Hospital was a plaintiff below and remains a cross-appellee here.

final order entered in the District Court for the District of Nebraska. *Good Samaritan Hospital v. Sullivan,* No. CV88-L-523 (D. Neb. Feb. 16, 1990) (order and memorandum). The Secretary of Health and Human Services (Secretary) cross-appeals from this final order. In the district court, both sides agreed that summary judgment was appropriate because the facts were not in dispute, and the district court granted partial summary judgment in favor of each side. For reversal, appellants argue that (1) the Secretary's refusal to reclassify Memorial Community Hospital as an urban hospital is arbitrary and capricious, (2) the Provider Reimbursement Review Board improperly denied jurisdiction over three cost years, and (3) the district court erred in granting relief that it did. For reversal, the Secretary argues that (1) this court lacks jurisdiction over Mary Lanning Memorial Hospital[2] and (2) the district court erred in allowing appellants a retroactive change in the prescribed methods of Medicare reimbursement. For the reasons discussed below, we affirm in part and reverse in part.

I. BACKGROUND FACTS

A. *Medicare Reimbursement Structure*

Under Part A of Medicare, health care providers, in this case hospitals, are reimbursed for providing medical services to Medicare patients. *See* Title XVIII of the Social Security Act, *as amended,* 42 U.S.C. § 1395 *et seq.* (the Medicare Act). Hospitals participate as "providers of services" by entering into an agreement with the Secretary.

[2] The Secretary originally argued that we also lack jurisdiction over Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County and St. Mary's Hospital, but the government changed its position in its reply brief.

Id. § 1395x(u). Providers are reimbursed for the lesser of "reasonable costs" or the "customary charges" for services furnished to Medicare beneficiaries. *Id.* § 1395f(b)(1). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." *Id.* § 1395x(v)(1)(A).[3] Reasonable cost is determined in accordance with regulations promulgated by the Secretary and these regulations

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, [and] may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services.

Id. In addition, the Medicare Act requires the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." *Id.* § 1395x(v)(1)(A)(ii) (clause (ii)).

In 1972, Congress authorized the Secretary to promulgate regulations which establish limits on the costs to be recognized as reasonable. Pub. L. No. 92-603, 86 Stat. 1329 (1972). Pursuant to this statutory authority, the Secretary first promulgated regulations establishing limits on hospital inpatient general routine care in 1974. 20 C.F.R. § 405.460

[3] After October 1, 1983, providers are reimbursed under the Medicare Prospective Payment System (PPS). *See* 42 U.S.C. § 1395ww(d). This case involves pre-1983 cost years and thus PPS is inapplicable.

(1975), *redesignated as* 42 C.F.R. § 413.30 (1990). These regulations establish specific cost limits based on factors including type of services furnished, geographical location, institutional size, nature and mix of services furnished, and type and mix of patients treated. 42 C.F.R. § 413.30(b) (1990). Providers can request an exemption or exception under specific statutory criteria and procedures. *See id.* § 413.30(e), (f) (1990).[4] These cost schedules are updated yearly. Initially, these cost schedules categorized hospitals by (1) whether they were located in a Standard Metropolitan Statistical Area (SMSA), (2) the per capita income of the location area and (3) bed size. SMSAs are used to distinguish urban and rural hospitals. Those hospitals located within a SMSA are considered urban and thus receive a higher per capita limit than rural hospitals (those located outside of SMSAs). *See* 44 Fed. Reg. 31,806 (1979). Changes to SMSA designations, based upon later census data, are applied solely to fiscal years following the effective date of the change.

In 1979, the Secretary promulgated new regulations to change one part of the cost limits. Rather than using area per capita income to adjust for variations in wage levels, a wage index was developed. *Id.* To determine the wage index, the Bureau of Labor Statistics of the Department of Labor divided the total hospital wages paid in one year by the total number of hospital workers to arrive at an average monthly hospital wage. This data did not take into account the number of full or part-time workers at any given hospital until 1984 when Congress required the Secretary to conduct a study to develop a wage index that would adjust for part-time workers. A new wage index was applied prospectively effective May 1, 1986. Pub. L. No. 99-272, § 9103(a), 100 Stat. 156 (1986).

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[4] Both appellants and the Secretary agree that none of these regulatory exceptions or exemptions is applicable in the present case.

In order to receive reimbursement, a provider is required to file an annual cost report with a fiscal intermediary (such as Blue Cross). 42 C.F.R. § 413.20 (1990). The fiscal intermediary reviews the cost report, determines the amount of reimbursement due the provider, and issues a "notice of program reimbursement" (NPR). *Id.* If the provider is dissatisfied with the NPR, the provider can file, within 180 days of receiving the NPR, a request for a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. § 1395oo(a). A PRRB decision that it lacks the authority to decide a question of law is considered a final agency decision and the provider may, within 60 days, seek judicial review. *Id.* § 1395oo(f)(1).

B. Facts in the Present Case

Appellants are rural Nebraska hospitals who exceeded the Secretary's promulgated cost limits in the early 1980s and filed appeals to the PRRB challenging the NPRs for the following cost years: Good Samaritan Hospital, 1981, 1982, 1983; Memorial Community Hospital, 1980, 1981, 1982, 1983; Memorial Hospital (Seward), 1980, 1982, 1983; Memorial Hospital of Dodge County, 1981, 1982, 1983, 1984; St. Mary's Hospital, 1980, 1982, 1983; and Mary Lanning Memorial Hospital, 1981, 1982, 1983. Additionally, three hospitals, which were parties to a prior group appeal, neglected to raise any issues concerning certain cost years, and therefore, the PRRB denied jurisdiction over the following cost years: Memorial Hospital (Seward), 1981; Memorial Hospital of Dodge County, 1980; and St. Mary's Hospital, 1981. Appellants challenged the fact that Medicare cost limits (1) did not account for the use of a high percentage of part-time employees, (2) did not permit rural hospitals to show they incurred the same costs as urban hospitals, and (3) were applied in a conclusive rather than a pre-

sumptive fashion. Memorial Community Hospital also challenged the denial of its request to be reclassified as an urban hospital.

Appellants claim that the wage-index regulations, by not accounting for part-time workers, disadvantage hospitals which employ a greater percentage of part-time workers than the average hospital. A hospital with a greater percentage of part-time workers will have a lower average monthly hospital wage. Because average monthly hospital wage is one factor used to determine the per diem limit for a given region, hospitals in that area will be disadvantaged. Appellants allege that rural Nebraska hospitals hire a greater percentage of part-time workers than the national average and thus they are disadvantaged by the Secretary's system. A study commissioned by appellants showed that an 11.04 percent adjustment factor applied to the wage index would correct for the failure to account for part-time employees. Following the Secretary's 1984 study of the disparity created by not distinguishing between full and part-time employees, the revised wage index (which went into effect in 1986) increased the rural Nebraska wage index by 11.25 percent. 50 Fed. Reg. 24,403 (1985). Appellants allege that a corrective factor should be applied to the cost years in question to correct for the disadvantage suffered by them prior to 1986.

As to the distinction between rural and urban hospitals, appellants allege that they are located so close to metropolitan areas that their wages were comparable to the wages of urban hospitals. Appellants allege that the classification of urban and rural hospitals is arbitrary and capricious. Appellants argue that they should be allowed to present evidence to show that they pay comparable wages and then should be reclassified as urban hospitals for the years in question.

The PRRB granted appellants' request for expedited judicial review, allowing appellants to take their challenge directly into district court. The district court, on cross-motions for summary judgment, ruled in favor of appellants insofar as it held that the cost limits may be applied only on a presumptive rather than a conclusive basis. The district court found that the Secretary had a statutory duty to make corrective adjustments under *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987) (*St. Paul-Ramsey*). In doing so, the district court further ruled that *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988) (*Georgetown*), did not overrule, and was in fact consistent with, *St. Paul-Ramsey*. The district court remanded the case to the Secretary to determine under clause (ii) whether appellants are entitled to reimbursement of reasonable costs beyond the amount already determined as reasonable under the cost schedule. The district court upheld the Secretary's refusal to reclassify Memorial Community Hospital as an urban hospital for the years 1980 to 1983 and the PRRB's denial of jurisdiction over the single-year cost limit challenges of Memorial Hospital (Seward), Memorial Hospital of Dodge County and St. Mary's Hospital.

Appellants then appealed to this court claiming error in the district court's (1) refusal to reclassify Memorial Community Hospital, (2) denial of jurisdiction with respect to single-cost years, and (3) remedy. The Secretary cross-appealed claiming (1) Mary Lanning Memorial Hospital lacked jurisdiction to appeal and (2) the district court erred in finding that the Secretary's methods of provider reimbursement are presumptive only and that appellants are entitled to relief under clause (ii).

II. JURISDICTION

There is a threshold issue of jurisdiction as to Memorial Community Hospital (Seward), Memorial Hospital of Dodge County, St. Mary's Hospital, and Mary Lanning Memorial Hospital because they were not named in the Notice of Appeal which stated in part that "[n]otice is hereby given that Plaintiffs, Good Samaritan Hospital, et al., hereby appeal." Rule 3(c) of the Federal Rules of Appellate Procedure as construed in *Torres v. Oakland Scavenger Co.*, 487 U.S. 312 (1988) (*Torres*), requires that each party be named in the notice of appeal and the use of "et al." is insufficient notice of appeal. *Id.* at 318; *see Wise v. Parkman*, 932 F.2d 745 (8th Cir. 1991); *United States v. Schneider*, 926 F.2d 777 (8th Cir. 1991) (*Schneider*); *Goos v. ICC*, 911 F.2d 1283 (8th Cir. 1990). Therefore, the use of "et al." in the notice of appeal does not give this court jurisdiction over any of the hospitals except Good Samaritan Hospital.

In spite of the strict jurisdictional rule established in *Torres*, we hold that we have jurisdiction over Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital, but dismiss the appeal of Mary Lanning Memorial Hospital for lack of jurisdiction. The *Torres* Court recognized that "if a litigant files papers in a fashion that is technically at variance with the letter of a procedural rule, a court may nonetheless find that the litigant has complied with the rule if the litigant's action is the functional equivalent of what the rule requires." 487 U.S. at 316-17 (citation omitted). In the present case, appellants filed an Appeal Information Form at the same time as their notice of appeal (thus within the sixty days for appeal). In this Appeal Information Form, appellants set forth their issues on appeal (emphasis added):

> Whether the District Court erred in determining that the Defendant's refusal to reclassify *Memorial Community Hospital* as an urban hospital for the period prior to June 1983, was not arbitrary and capricious.
>
> Whether the District Court erred in dismissing the claims of *St. Mary's Hospital* for fiscal year 1981, *Memorial Hospital (Seward)* for fiscal year 1981, and *Memorial Hospital of Dodge County* for fiscal year 1980.

Therefore, the issue in this case becomes whether this Appeal Information Form is "a functional equivalent of what the rule requires." We hold that it is. The Appeal Information Form was filed within the time required for the notice of appeal and provided the Secretary with clear notice that the four hospitals listed are appealing the district court's order. While this is a case of first impression in this circuit, we agree with other circuits which have held that additional documents filed within the statutory period for notices of appeal are the functional equivalent of a notice of appeal and, therefore, serve as a notice of appeal. The Third Circuit in *Dura Systems, Inc. v. Rothbury Inv., Ltd.*, 886 F.2d 551, 555 (3d Cir. 1989), *cert. denied*, 493 U.S. 1046 (1990), held that a Consent Order could serve as the functional equivalent of what Rule 3(c) required when filed within the time for filing an appeal under Fed. R. App. R. [*sic*] 4. *Accord Warfield v. Fidelity & Deposit Co.*, 904 F.2d 322 (5th Cir. 1990). The Fifth Circuit explained that the defect in the notice of appeal of not specifically naming the parties appealing can be cured "by filing a supporting memorandum or some other paper which contains the name of each appellant." *Id.* at 325 (citations omitted).[5] Moreover, this

[5] The Seventh Circuit takes a different approach and does not adopt this collateral document rule and thus requires that each party be named in the notice of appeal. *Allen Archery, Inc. v. Precision Shooting Equip., Inc.*, 857 F.2d 1176 (7th Cir. 1988) (per curiam). We decline to adopt the approach of the Seventh Circuit.

approach is consistent with Eighth Circuit precedent. In *Schneider,* this court found a lack of jurisdiction because "the 'certificate of interested persons' [which listed each appellant not named on the notice of appeal] was submitted after the appeal time had expired." 926 F.2d at 778.

We hold that when the collateral document naming the specific parties is filed within the appeal time, jurisdiction exists over those parties. We therefore hold that we have jurisdiction over Good Samaritan Hospital as well as Memorial Community Hospital, Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital. The appeal of Mary Lanning Memorial Hospital is dismissed for lack of jurisdiction.

III. ISSUES ON THE MERITS

We review the district court's grant of summary judgment de novo. We thus apply the same standard of review as the district court, that is, whether the Secretary's actions are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *Hennepin County v. Sullivan,* 883 F.2d 85, 91 (D.C. Cir. 1989) (*Hennepin County*), *cert. denied,* 493 U.S. 1043 (1990).

A. Scope of Secretary's Duty under clause (ii)

Appellants insist that the Medicare cost limits for the cost years in question did not reimburse their reasonable costs as required under 42 U.S.C. § 1395x(v)(1)(A). Appellants urge this court to affirm the district court's findings that the cost limits are to be applied presumptively and that providers are entitled under *St. Paul-Ramsey* to suitable retroactive corrective adjustments where the cost limits methodology fails to reimburse their actual reasonable costs. On cross-appeal, the Secretary argues that the district court erred in relying on *St. Paul-Ramsey* because that decision

has been overruled by the Supreme Court in *Georgetown.* The Secretary claims that clause (ii) only authorizes year-end book-balancing, not retroactive modifications to the cost limits rules.

Because the district court remanded the claims of all six hospitals to the Secretary for further proceedings to determine if they were entitled to additional reimbursement for reasonable costs, Mary Lanning Memorial Hospital remains a cross-appellee for the limited purposes of this issue. We will continue to use the term "appellants" for the cross-appellees, but Mary Lanning Memorial Hospital is included only for the limited purposes of the clause (ii) analysis.

Clause (ii) requires that regulations "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii). We interpreted this statute in *St. Paul-Ramsey* and concluded that cost limits were only presumptive and "that § 1395x(v)(1)(A) imposes a statutory duty upon the Secretary *whenever* the chosen method of cost calculation fails to adequately reimburse all reasonable costs." 816 F.2d at 420 (citations omitted) (emphasis in original).

Our interpretation of clause (ii) in *St. Paul-Ramsey* was overruled by the Supreme Court in *Georgetown. Georgetown* presented the question "whether the Secretary may exercise this rulemaking authority to promulgate cost limits that are retroactive." 488 U.S. at 206. In 1983, the Secretary's 1981 wage-index rule was struck down for violating the notice and comment provisions of the Administrative Procedure Act. *Id.* After following the proper procedures, the Secretary enacted the wage-index rule in 1984 but tried to apply it retroactively to 1981. The Supreme Court held

that clause (ii) does not provide the "authority for the retroactive promulgation of cost-limit rules." *Id.* at 209. The Court explained that

> clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudiciation, not to rulemaking.

Id. (footnote omitted). The Court drew a distinction between clause (i) of § 1395x(v)(1)(A) which speaks of "providers" and clause (ii) which uses the term "a provider." "The distinction suggests that clause (ii), rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers." *Id.* at 210. Finally, the Court concluded that clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts.

> [C]lause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. . . . [N]othing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

Id. at 211 (emphasis in original). Therefore, clause (ii) merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year. *See id.* at 213 (citations omitted).

Appellants claim that they are not requesting a change in the method of calculating reimbursement, but merely want their aggregate reimbursements adjusted because the flaws in the existing methodology caused underreimbursement of their reasonable costs. Appellants claim that this does not amount to change of methodology or a retroactive change in the cost limit regulations as forbidden by *Georgetown*.

We disagree. Appellants are asking for retroactive rule changes, not merely the year-end book balancing allowed in *Georgetown*. Appellants do not claim that the Secretary inaccurately applied the cost methodology in place during the cost years in question. Instead, appellants want the methodology changed to correct what they believe are inequalities in the system. While they claim this is merely case-by-case analysis, it is not. Appellants are asking this court to order the Secretary to retroactively adjust cost limits for the number of part-time workers. Such relief would amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown,* is invalid. Clause (ii) does not allow this court to reevaluate the appropriateness of the cost limit regulations, but only to reevaluate the calculations made pursuant to those regulations. *See Hennepin County,* 883 F.2d at 93.

The D.C. Circuit faced a similar situation in *Hennepin County* where a hospital sought additional reimbursement for medical education expenses. The hospitals claimed that because of its large medical education program, its expenses exceeded those of other hospitals and cited *St. Paul-Ramsey* in support. *Id.* at 90. The court rejected the argument of hospitals and noted "that *St. Paul-Ramsey* violated the rule against retroactive rulemaking." *Id.* The court explained that the hospital had received all that it was entitled to under the existing methodology, and that "[s]ection 1395x(v)(1)(A)(ii) is not a vehicle through which Medicare

providers may get a 'second bite at the apple.' " *Id.* at 92. *Accord Sierra Medical Center v. Sullivan,* 902 F.2d 388 (5th Cir. 1990). Appellants here are asking this court for a second bite at the apple because they feel cheated by the cost limit regulations. Clause (ii) does not allow such a result.

B. Cost Limit Rules' Validity

All appellants, during the years in question, were located outside of designated SMSAs and were thus classified as rural hospitals for the purposes of determining cost limits. They received a lower cost limit than hospitals within SMSAs and appellants claim they must compete with urban hospitals for staff. Appellants argue that the cost limit regulations are arbitrary and capricious because they fail to account for the use of part-time employees and use the SMSA designations as the sole means by which a hospital can be designated as an urban hospital. Appellants allege that the percentage of part-time employees in rural Nebraska hospitals was 44 percent while the national average was only 26 percent. Appellants claim that the Secretary knew of this inherent distortion in the wage index methodology, but did nothing to correct it until Congress forced the Secretary to do so in 1984. *See* Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081 (1984).

We disagree with appellants and find the cost limit rules reasonable and valid. Simply because the Secretary later altered the wage index to account for part-time employees does not mean that the limits prior to the change are invalid. *See City of Austin v. Heckler,* 753 F.2d 1307, 1315 (5th Cir. 1985). To so hold would simply discourage the Secretary from changing and improving the regulations. At the time the regulations were in place, the Secretary claims that they were based upon the latest available data. *See* 44 Fed. Reg. 31,807 (1979). There is nothing arbitrary or

capricious about the cost limit methodology used by the Secretary. Both the wage index and the rural/urban distinction were based on objective data and regulations, and we hold the SMSA-based cost limit regulations are not arbitrary or capricious.

C. Classification of Memorial Community Hospital

Appellant Memorial Community Hospital (MCH) appeals the district court's affirmance of the Secretary's denial to reclassify it as an urban hospital for the years 1980 to 1983. Data from the 1980 census shows MCH located within the Omaha SMSA, but MCH's reclassification as an urban hospital was not effective until June 30, 1983. Therefore, MCH argues that because the census data shows that it had been operating as an urban hospital at least since 1980, it was arbitrary and capricious for the Secretary to deny the retroactive reclassification. We agree with the district court that to reclassify MCH as an urban hospital would violate the prohibition against across-the-board retroactive modifications in *Georgetown.* We therefore affirm the district court on this issue.

MCH argues that reclassification is required so that it is reimbursed for its reasonable costs. Additionally, MCH alleges this is not retroactive rulemaking because it is only requesting a case-by-case adjustment to its aggregate reimbursement, not an across-the-board change.[6] MCH is

[6] All of the cases on which Memorial Community Hospital relies are pre-*Georgetown* cases. Beyond that distinction, the two main cases deal with initial SMSA determinations and the use of different criteria in different parts of the county. *Addison Gilbert Hosp. v. Blue Cross Assoc./Blue Cross of Mass.*, Medicare & Medicaid Guide (CCH) ¶30,783 (HCFA Nov. 10, 1980); *Anna Jacques Hosp. v. Blue Cross Assoc./Blue Cross of Mass.*, Medicare & Medicaid Guide (CCH) ¶30,025 (PRRB July 16, 1979), *aff'd,* Medicare & Medicaid Guide (CCH) ¶30,781 (HCFA Sept. 14, 1979). The analysis of these cases, therefore, does not apply to reclassification based on new data and the retroactive application of that reclassification.

mischaracterizing its request. MCH is asking this court to engage in retroactive rulemaking. If the Secretary had to reclassify MCH based on the 1980 census data, then the Secretary would also have to retroactively reclassify all hospitals which changed SMSA classification as a result of the 1980 census data. This would amount to retroactive rulemaking which is forbidden under *Georgetown*.

D. PRRB Denial of Jurisdiction

The PRRB denied jurisdiction over the appeals of Memorial Hospital (Seward) for fiscal year 1981, Memorial Hospital of Dodge County for fiscal year 1980, and St. Mary's Hospital for fiscal year 1981 on the ground that the cost limit appeals were not filed within 180 days of the NPR as required by 42 U.S.C. § 1395oo(a)(3). The district court affirmed the decision of the PRRB. These three appellants seek to raise claims identical to those raised in the other cost years appealed. Therefore, because we denied relief for the cost years properly appealed, we need not reach this jurisdictional issue. Even if jurisdiction existed, the underlying claims would be denied.

E. Remedy

Appellants also challenge the relief granted by the district court. Appellants argue that the district court should have ordered the Secretary to apply an 11.25 percent adjustment factor to account for the disparity in part-time workers instead of just remanding the case for a determination of the appropriate reimbursement. Because we have decided that appellants are entitled to no relief, this issue is moot.

IV. CONCLUSION

Accordingly, we dismiss the appeal of Mary Lanning Memorial Hospital for lack of jurisdiction. We reverse the district court's grant of summary judgment in favor of appellants and hold that appellants are entitled to no corrective adjustment. We affirm the district court's grant of summary judgment in favor of the Secretary (1) denying MCH retroactive reclassification as an urban hospital and (2) denying jurisdiction to Memorial Hospital (Seward) for fiscal year 1981, Memorial Hospital of Dodge County for fiscal year 1980, and St. Mary's Hospital for fiscal year 1981.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 90-1641NEL

GOOD SAMARITAN HOSPITAL, ETC., ET AL., APPELLANTS,

v.

LOUIS W. SULLIVAN, ETC., APPELLEE.

Order Denying Petition for Rehearing and
Suggestion for Rehearing En Banc

The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

February 7, 1992

Order Entered at the Direction of the Court:

/s/ Michael E. Gans
Clerk, U.S. Court of Appeals, Eighth Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

MEMORANDUM AND ORDER ON CROSS-MOTIONS
FOR SUMMARY JUDGMENT

The plaintiffs in this action under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, are six hospitals licensed as general acute care hospitals by the State of Nebraska: Good Samaritan Hospital, The Mary Lanning Memorial Hospital, Memorial Community Hospital, Memorial Community Hospital of Dodge County, Memorial Hospital (Seward), and St. Mary's Hospital Corporation. The defendant, Louis W. Sullivan, is the Secretary of Health and Human Services and is responsible for the administration of the Department of Health and Human Services (HHS), including the Medicare program. The plaintiffs challenge the defendant's conclusive application of cost limits in reimbursing Medicare providers. The plaintiffs and the defendant have filed motions for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. The defendant has filed a two-volume administrative record (A.R.) and a four-volume rulemaking record (R.R.). The parties have stipulated that the issues in this case are questions of law and that the case should be decided on the cross-motions for summary judgment. Filing 11.

I.

Under the Medicare program, health care providers are reimbursed by the federal government for expenses incurred in providing medical services to Medicare beneficiaries. *See* Title XVIII of the Social Security Act, *as amended,* 42 U.S.C. § 1395 *et seq.* (the Medicare Act). The plaintiffs are six Nebraska hospitals that participate as providers of services in the Medicare program.

Medicare providers are to be reimbursed based on the "reasonable cost" or the "customary charge", whichever is less, for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). "Reasonable cost" is "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A). The 1972 amendments to the Act, in effect during the years in question, authorized the Secretary to utilize a schedule of limits to determine a provider's reasonable costs. The reasonable costs were to be determined "in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . . ." *Id.* Such regulations:

> may provide for determination of the costs of services on a per diem basis, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the costs or incurred costs of specific items or services . . . to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services . . . and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

Id. The regulations shall:

> take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . .

Id. at § 1395x(v)(1)(A)(i).

The regulations must also "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." *Id.* at § 1395x (v)(1)(A)(ii) (hereafter referred to as clause ii).

The Secretary first promulgated regulations establishing cost limits in 1974, 42 C.F.R. § 405.460, *redesignated as* 42 U.S.C. § 413.30. *See* 39 Fed. Reg. 20,164 (1974). The Secretary adopted the first schedule of cost limits that same year, 39 Fed. Reg. 30,164 (June 6, 1974), and has published updated yearly schedules prior to the beginning of the cost reporting periods to which the limits are applicable. Beginning in 1979, the Secretary incorporated into the cost limits an area wage index designed to adjust the wage component of the cost limit schedules to reflect differing wage levels among the areas in which hospitals are located. 44 Fed. Reg. 31,806 (June 1, 1979), R.R. 508. The Secretary concluded that ES-202 data from the Employment and Wages Program was the best data available for use in calculating a wage index. Under the ES-202 program, each employer in a state provides information to the State unemployment insurance agency regarding the total number of workers on

an employer's payroll during each month, total wages paid, and taxable wages, which is in turn supplied to the Bureau of Labor Statistics of the Department of Labor (BLS). A.R. 184. The Secretary chose to use ES-202 data from the "hospital group", a standard BLS reporting category. R.R. 509.

In formulating the cost limits, the Secretary also distinguished between urban and rural hospitals by determining whether a hospital was located within a Standard Metropolitan Statistical Area (SMSA) as designated by the Executive Office of Management and Budget. 44 Fed. Reg. 31,806 (June 1, 1979), R.R. 508. A SMSA is a geographical area with a large population nucleus, including surrounding communities that have a high degree of economic and social integration with that nucleus. A.R. 288. Rural hospitals routinely received a lower per diem cost limit amount than urban hospitals. The plaintiff hospitals were classified as rural, non-SMSA hospitals during the cost years in question.

For each SMSA and non-SMSA county, BLS divided the total hospital wages paid during the year by the total number of hospital employees working each month during the year to arrive at an "average monthly hospital wage." A.R. 183-186. The data regarding the number of hospital employees collected by BLS did not distinguish between full-time and part-time employees. The result is that an area with a high proportion of part-time to full-time employees on its payrolls will have a lower area monthly wage than an area with a lower proportion of part-time employees.

The Medicare program reimburses providers of services through a fiscal intermediary, in this case Blue Cross of Nebraska. Providers receive periodic interim payments based on a billing submitted to the fiscal intermediary. After the close of its fiscal year, a provider of services submits a "cost report" reflecting costs incurred during the fiscal

year and an apportionment of those costs between Medicare and non-Medicare patients. The intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit, if an audit is performed. Each plaintiff was supplied by Blue Cross of Nebraska with a Medicare hospital inpatient rural Nebraska per diem cost limit figure for each fiscal year under appeal as calculated by Blue Cross of Nebraska according to the Medicare cost limits regulations and cost limits schedule. No exception was available under the cost limit regulations by which a hospital could have the BLS-computed wage index recalculated to adjust for part-time employee use. In addition, the SMSA designation was the only basis the agency would recognize in determining whether a hospital was considered urban or rural. Hospitals could be reclassified as urban pursuant to 42 C.F.R. 405.460(d) (now § 413.30(d)), and hence receive a higher wage index, only if they were erroneously classified as outside a SMSA when in reality they were located within a SMSA. A.R. 199.

The plaintiffs filed appeals to the Provider Reimbursement Review Board (PRRB) challenging the "Notices of Proposed Reimbursement" for the following cost years: St. Mary's, 1980, 1982, 1983; Mary Lanning, 1981, 1982, 1983; Good Samaritan, 1981, 1982, 1983; Memorial Community, 1980, 1981, 1982, 1983; Memorial Hospital (Seward), 1980, 1982, 1983; Memorial Hospital of Dodge, 1981, 1982, 1983, 1984. Three of the hospitals filed group appeals, raising issues other than cost limits, for the following years: St. Mary's, 1981; Memorial Hospital (Seward), 1981; and Memorial Hospital of Dodge, 1980. In 1984 the plaintiffs sought to raise the cost limits issue in these appeals. (A.R. 85)

On July 22, 1988, the plaintiffs filed a request for expedited review. (A.R. 19). The Board held that it was without authority to decide the questions of whether the cost limits

were valid and whether the conclusive application of these limits was proper and granted expedited review, allowing the plaintiffs to bypass the Board's hearing procedure and obtain judicial review. It further determined that it lacked jurisdiction to hear the cost limit claims for the following cost years because the hospitals had not filed timely appeals: St. Mary's, 1981; Memorial Hospital (Seward), 1981; and Memorial Hospital of Dodge, 1980. A.R. at 3-4, 11-12, 17-18.

Plaintiff Memorial Community Hospital is located in Washington County, Nebraska. In 1983, the Office of Management and Budget determined that Washington County would be redesignated as part of the Omaha SMSA on the basis of 1980 census data, effective June 30, 1983. A.R. at 288. The Health Care Financing Administration (HCFA) did not apply the reclassification retroactively. A.R. at 590-91. Memorial Community Hospital was denied reclassification as an urban hospital for the 1980, 1981, and 1982 cost years.

The plaintiffs assert that the failure of the defendant to account for the use of part-time employees and the defendant's use of SMSA's as the sole criterion for designating hospitals as urban or rural in formulating cost limits has resulted in inaccurate reimbursement, and they seek reimbursement beyond the amount determined by the Secretary to constitute "reasonable costs" under the cost limits rules. They base their request on two alternative claims. The first is that the Secretary has a statutory duty under clause (ii) to make corrective adjustments whenever necessary to ensure that all reasonable costs are reimbursed. In the alternative they allege that the cost limit regulations and schedules are arbitrary and capricious and that they are entitled to reimbursement for their reasonable costs for the years under appeal without regard to the cost limits. Plaintiff Memorial Community Hospital also contends that the

defendant's refusal to reclassify it as being located within the Omaha SMSA beginning with its 1980 cost year was arbitrary, capricious, an abuse of discretion, and contrary to law. Finally, Memorial Hospital of Dodge County, Memorial Hospital (Seward), and St. Mary's Hospital allege that the PRRB's decision that it did not have jurisdiction over their appeals with respect to the cost limits issues in the years 1980, 1980 [*sic, should be 1981*], and 1981, respectively, was arbitrary, capricious, an abuse of discretion and contrary to law.

II

In reviewing agency actions under the Medicare statute, courts are governed by the judicial review provisions of 5 U.S.C. § 701-706 (1976). 42 U.S.C. § 1395oo(f)(1). Under 5 U.S.C. § 706(2) a reviewing court is directed to hold unlawful and set aside agency action, findings, and conclusions found to be "(a) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; [or] . . . (c) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . ." Courts must give deference to the interpretation given of a statute by the agency charged with its administration. *Research Medical Center v. Schweiker*, 684 F.2d 599 (8th Cir. 1982). However, when a court is presented an issue concerning an agency's interpretation of congressional intent, as opposed to an issue of whether an agency made a correct policy choice, the court need not accord a high level of deference to the Secretary's interpretation of a statute. *Bureau of Alcohol, Tobacco & Firearms v. Federal Labor Relations Auth.*, 464 U.S. 89, 98 n. 8 (1983) ("When an agency's decision is premised on its understanding of a specific congressional intent, however, it engages in the quintessential judicial function of deciding what a statute means. In that case, the agency's interpretation . . . may be influential, but it cannot bind a court")

The first issue is whether the Secretary has the authority to apply the cost limit schedules on a conclusive basis, or whether the Secretary must instead allow the plaintiffs an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined reasonable under the cost limit schedule.

The plaintiffs contend that their reimbursement under the cost limit schedule was inadequate due to the failure of the BLS data, used in formulating the wage index, to distinguish between full-time and part-time employees. BLS received data on the total hospital wages paid and the total number of hospital employees working during a given month. From this data the BLS computed an average monthly hospital wage. The number of employees counted included all personnel, including part-time employees. A.R. 184. Under this method every hospital employee who worked during a month was counted with equal weight. Therefore a hospital that has total monthly wages of $100,000 and employs 100 full-time employees would have an average monthly hospital wage of $1,000. But if the same hospital, again with total monthly wages of $100,000 employed 200 part-time employees, BLS calculations would show an average monthly wage of only $500. Thus, if rural hospitals in a given state employ a high percentage of part-time employees, the non-SMSA wage index for these hospitals will be distorted downward. In a study dated October 11, 1983, the Nebraska Hospital Association reported that after reviewing the percentage of part-time employees for Nebraska and the nation it was apparent that Nebraska exceeded the national average. It found that the national average of part-time employees in non-SMSA areas in 1980 was 26%, while the average of part-time employees in non-SMSA areas in Nebraska was 44%. It noted that Nebraska would experience a substantial increase in its wage index

if it were adjusted for the impact of part-time employees. A.R. 129, 132.

The plaintiffs (with the exception of Memorial Hospital, Seward, who does not join in this challenge) also allege that they were denied adequate reimbursement under the non-SMSA designation due to the fact that they incurred costs comparable to those of SMSA hospitals in Nebraska in the period 1980 through 1983. Memorial Hospital of Dodge County is located 6 miles from the Omaha SMSA, Memorial Community Hospital is located 25 miles from the Omaha SMSA, St. Mary's is located 50 miles from the Omaha and Lincoln SMSA's, Good Samaritan is located 124 miles from the Lincoln SMSA and Mary Lanning is located 100 miles from the Lincoln SMSA and 160 miles from the Omaha SMSA. The plaintiffs located within 50 miles of a SMSA allege that they directly competed with SMSA hospitals to attract staff. Good Samaritan and Mary Lanning allege that they had to offer SMSA-level wages to attract staff out to their remote locations. The hospitals have submitted data showing that their average hourly wages and average starting salaries for registered nurses were comparable to the urban hospitals in Nebraska. A.R. 128, 422, 533, 831, 927. For these reasons the plaintiffs believe they are entitled to corrective adjustment under clause (ii).

The Secretary disagrees and contends that section (1)(a) gives him the authority to apply the cost limits as conclusive evidence of which costs are reasonable rather than having to develop cost schedules on a case-by-case basis. To adopt the plaintiffs' interpretation of clause (ii), the Secretary argues, would be to render meaningless the regulations established to determine reasonable costs. Instead, he believes that clause (ii) only authorizes a year-end "book balancing" adjustment of the monthly installments received by the provider to ensure that the provider receives what it is due under the cost limits as applied. Under the Secre-

tary's view clause (ii) does not authorize the reimbursement of any costs which exceed the cost limits.

I disagree. The 1972 amendments must be construed to authorize the Secretary to develop and apply presumptive, not conclusive, cost limits. The legislative history of the 1972 amendments supports this finding. ". . . [T]he evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable . . ." H.R. Rep. No. 231, 92nd Cong., 2nd Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News, 4989, 5070. "Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 5071.

The Secretary claims that to allow the plaintiffs reimbursement under clause (ii) would nullify the purpose of formulating cost limits in the first place. Other courts that have considered this issue have disagreed with that position.

> Prior to the 1972 amendments, reimbursements were calculated individually for each provider on a retrospective basis. That method generally led to reimbursement for all costs which providers had incurred, whether necessary and efficient or not, because it was extremely difficult for the Secretary to establish that a specific cost was unreasonable . . . The use of prospective payments regulated by a schedule of limits shifted the burden of proving the reasonableness of costs exceeding the presumptive limit to the provider . . ." (citations and footnote omitted)

Regents of U. of Cal. v. Heckler, 771 F.2d 1182, 1190 (9th Cir. 1985)

> This interpretation does not, as the Secretary suggests, render the 1972 amendments a "nullity". As the legislative history indicates, presumptive cost limits can serve several useful purposes . . . [T]he cost limit methodology enables intermediaries to disallow costs in the first instance without having to engage in a case-specific evaluation of reasonableness. Before the adoption of the cost limit methodology, an intermediary could disallow a provider's costs in the first instance only to the extent it would establish that the provider's costs were "substantially out of line" with comparable facilities in the provider's geographic vicinity. Congress apparently came to regard this approach as adequate, and determined that the cost limit methodology would provide a more effective means for evaluating reimbursement claims . . ." (citation and footnote omitted)

Medical Center Hospital v. Bowen, 839 F.2d 1504, 1512 (11th Cir. 1988)

I agree that to allow the plaintiffs the opportunity to demonstrate that their costs in excess of the cost limits were reasonable does not render useless the cost limits themselves. The Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs. *St. Paul-Ramsey Medical Center v. Bowen,* 816 F.2d 417 (8th Cir. 1987). There the plaintiff hospital sought review of the Secretary's decision to deny reimbursement for increased costs of operating a graduate medical program for the fiscal year ending December 31, 1980. The court held that section (1)(a) imposes a statutory duty upon the Secretary to reimburse adequately all reasonable costs whenever the chosen method

of cost calculation fails to reimburse adequately all reasonable costs, and that the Secretary's refusal to grant the hospital a retroactive corrective adjustment violated his statutory duty. It ordered the Secretary to apply retroactively the 1980 Indirect Teaching Cost Adjustment, a regulation that was not in effect during the year in question.

Similarly, the Circuit Court of Appeals for the District of Columbia has held that clause (ii) allows the Secretary to adjust provider reimbursement upon proof that his methods of determining costs, including the cost limit rules, resulted in inadequate or excessive reimbursement. At issue in *Georgetown Univ. Hosp. v. Bowen*, 821 F.2d 750 (D.C. Cir. 1987) was the ability of the Secretary to formulate cost limit rules and to apply them retroactively. In 1981 the Secretary had modified the wage-index to exclude data on wages paid by federally-owned hospitals, which he believed reduced the accuracy of the index. He did so without allowing for the required notice and comment period. Seven hospitals challenged his action in District Court. The court agreed that the Secretary's actions violated the Administrative Procedure Act (APA). The Secretary did not appeal the ruling, and instead settled the provider's accounts by using the wage-index rule in effect prior to his modifications. Three years later the Secretary reissued the 1981 wage-index rule and complied with the notice and comment requirements. This time, however, he made the rule retroactive to July 1, 1981, which was exactly the same accounting period that would have been covered had the District Court not struck down the rule.

The plaintiff hospitals again filed suit, this time challenging the rule's retroactive application. At no point in the litigation did the Secretary dispute the fact that Congress amended the Medicare statute in 1972 to authorize only prospective cost limit rules. He instead argued that clause (ii) authorized him to promulgate retroactive cost limit

rules. The court held that the Secretary's retroactive promulgation was not authorized by clause (ii). The court found a critical distinction between the power to promulgate retroactive rules of general application and the power to make retroactive corrective adjustments to particular providers when their aggregate reimbursement was either inadequate or excessive.

> The former power—if it existed—would be exceedingly broad, for it would permit the Secretary to issue a modified cost limit rule, and then automatically apply that rule across the board to all providers who had been reimbursed under the predecessor rule. The latter power, however, is far more limited, for it only allows the Secretary to adjust the reimbursements of particular providers upon proof that his "methods of determining costs" (including his cost-limit rules) resulted in inadequate or excessive reimbursements to those providers.

Id. at 759.

This decision was affirmed in *Bowen v. Georgetown Univ. Hosp.*, ____ U.S. ____, 109 S.Ct. 468, 57 U.S.L.W. 4057 (1988). The defendant argues that *Bowen* has overruled *St. Paul-Ramsey, supra,* and *Regents of Univ. of Calif., supra,* and that under the holding in *Bowen* he is not authorized to make corrective adjustments beyond what the applicable cost limits already allow.

To begin with, *Bowen* did not overrule *St. Paul-Ramsey* or *Regents of Univ. of Calif.* The *Bowen* court addressed the issue of the retroactive promulgation of cost limit rules and agreed with the lower court's findings.

> . . . [W]e agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to re-

> imbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking. /1.

57 U.S.L.W. at 4059.

Footnote 1 states in pertinent part that ". . . Other courts, without deciding whether clause (ii) permits rulemaking, have held that it requires the Secretary to make case-by-case adjustments to reimbursement determinations. *E.g., St. Paul-Ramsey Medical Center v. Bowen,* . . . ; *Regents of the University of California v. Heckler,* . . ." This footnote makes clear that the Court does not consider *St. Paul* and *Regents* to be in conflict with its holding. The Court went on to state that because clause (ii) refers to "a provider", its intent is to authorize a case-by-case inquiry into the accuracy of reimbursement determinations for individual providers, and not to permit modifications to the cost-method rules in their general formulation.

For the foregoing reasons I find that the plaintiffs are entitled to consideration of their reasonable expenses in excess of the cost limit rules in effect for the years under appeal.

The plaintiffs contend that if they are successful in obtaining reimbursement in excess of the cost limits for the years at issue, they are also entitled to an adjustment to their hospital specific rate under the Prospective Payment System (PPS), which is used for cost periods beginning on or after October 1, 1983. For the first four years of the PPS, a portion of a hospital's PPS payment is based on the hospital's reasonable costs in a prior "base year". All of the plaintiffs have their PPS base year (generally fiscal year 1982) as one of the years under appeal in this case. The defendant has

agreed that if the plaintiffs are successful in obtaining reimbursement that their PPS payment should be adjusted to reflect the additional base year. (Defendant's memorandum at p. 3).

III

The next issue is whether the Secretary's refusal to retroactively reclassify Memorial Community Hospital as an urban hospital was arbitrary and capricious. Memorial Community Hospital, located 20 miles from the Omaha SMSA, was classified by the Secretary as a rural hospital for the 1980, 1981, and 1982 cost years. In 1983 the Office of Management and Budget reclassified Washington County as part of the Omaha SMSA. The revised designation was obtained by applying new SMSA standards to selected demographic data produced by the 1980 decennial census. A.R. 590. The HCFA did not apply the classification retroactively. When it notified the hospital of their decision, the HCFA explained that new SMSA designations do not become effective until notification is given of the change in status, and that the new designation would not become official until after formal publication in June 1983. A.R. 590. The HCFA agreed that to adopt new SMSA designations retroactively would benefit those providers who were reclassified into a SMSA, but noted that those who lost their SMSA designation under the new classification system would then be subject to retroactive reduction of reimbursement, something the HCFA felt would not be equitable.

> We do not believe that this would be equitable because providers would not have known in advance of the cost reporting periods to which the limits apply what their official status could be expected to be. The idea that cost limits would be determined prospectively, that a provider would

> know the limit of Medicare reimbursement in advance of the cost reporting period to which it would be applied, was a major premise expressed in the committee reports which accompanied the law authorizing the cost limits.

A.R. 591.

For the Secretary to allow otherwise would have been to violate the Supreme Court's prohibition in *Bowen* against across-the-board retroactive modifications to the cost limit rules. I find that the refusal to reclassify Memorial Community Hospital was not arbitrary or capricious.

III

The final issue is whether the PRRB improperly denied jurisdiction over the appeals of three cost years. The PRRB denied jurisdiction over the appeals of St. Mary's Hospital for fiscal year 1981 (A.R. 3), Memorial Hospital (Seward) for fiscal year 1981 (A.R. 11) and Memorial Hospital of Dodge County for fiscal year 1980 (A.R. 17) on the ground that the cost limit appeals were not filed within 180 days of the date of the Notice of Program Reimbursement as required by 42 U.S.C. § 1395oo(a)(3). Each of the hospitals had argued that its appeal of the cost limit issues should be considered as having been timely filed because each of them had filed a timely appeal on other issues raised in group appeals for the same years in question. There is no dispute that the plaintiffs did not file their appeals on the cost limit issue within 180 days. Nevertheless, they contend that they should be allowed to raise their challenge to the cost limits for these years because they were participants in timely filed group appeals.

The Medicare Act provides two avenues of appeals. Under 42 U.S.C. § 1395oo(a) (section (a)) any provider of services that has filed a required cost report may obtain a

hearing with respect to such cost report. This request for a hearing must be filed within 180 days after notice of the intermediary's final decision. 42 U.S.C. § 1395oo(a)(3). The second is a group appeal pursuant to 42 U.S.C. § 1395oo(b) (section b). Under this provision a group of providers may file a group appeal if the matters in controversy involve a common question of fact or law. The plaintiffs cite 29 C.F.R. § 405.1841(a) (1974), *redesignated as* 42 C.F.R. § 405.1841, in support of their claim. That section states in pertinent part that "[t]he request for a Board hearing must be filed in writing with the Board within 180 days . . . Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof." But as the defendant points out, this section is not applicable to group appeals. 42 C.F.R. § 1837, entitled "Group appeal", states in subsection (b) that "[a] single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable." Those requirements include the one that the provider file a written request within 180 days of the notice of the intermediary's determination. *See* 42 C.F.R. § 405.1835(a)(2), which incorporates the time limits set forth in 42 C.F.R. § 405.1841(a). Thus, the fact that the plaintiffs were participants in a timely filed group appeal does not allow them to raise other issues not common to the group outside the 180-day period. The PRRB properly found that it lacked jurisdiction to review the challenges to the wage index for these cost years.

IT IS ORDERED that: (1) the plaintiffs' motion for summary judgment, Filing 12, is granted on the issue of corrective adjustment of cost limit rules and is otherwise denied; and (2) that the defendant's motion for summary judgment, Filing 14, is granted on all issues, except the issue of corrective adjustment of cost limit rules.

Dated February 16, 1990.

BY THE COURT

/s/ Warren K. Urbom
United States District Judge

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5054

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, Maryland 21202

Re: Good Samaritan Hospital, Provider No. 28-0009, Case No. 88-5054, FYEs – December 31, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid.

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1981	–	$223,500
December 31, 1982	–	$243,000
December 31, 1983	–	$112,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/hr

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5053

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: The Mary Lanning Memorial Hospital, Provider No. 28-0032, Case No. 88-5053, FYEs – December 31, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1981	–	$222,000
December 31, 1982	–	$227,000
December 31, 1983	–	$200,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To: JRB: 88-5055
Location: Professional Bldg. Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Community Hospital, Provider No. 28-0047, Case No. 88-5055, FYEs – December 31, 1980, 1981, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y		Amount
December 31, 1980	–	$29,000
December 31, 1981	–	$54,000
December 31, 1982	–	$59,000
December 31, 1983	–	$71,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5052

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Hospital of Dodge County, Provider No. 28-0077, Case No. 88-5052, FYEs – December 31, 1981, 1982, 1983, and 1984, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
December 31, 1981 –	$130,000
December 31, 1982 –	$157,000
December 31, 1983 –	$157,000
December 31, 1984 –	$ 85,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5051

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: Memorial Hospital (Seward), Provider No. 28-0058, Case No. 88-5051, FYEs – September 30, 1980, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
September 30, 1980 –	$31,000
September 30, 1982 –	$60,000
September 30, 1983 –	$14,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

AUG. 11, 1988

Refer To:
JRB: 88-5056

Location: Professional Bldg.
Room 104

Carel T. Hedlund, Esq.
Ober, Kaler, Grimes & Shriver
1600 Maryland National Bank Building
10 Light Street
Baltimore, MD 21202

Re: St. Mary's Hospital, Provider No. 28-0062, Case No. 88-5056, FYEs – September 30, 1980, 1982, and 1983, Request for a *Board Determination* that It Lacks the Authority to Decide Whether the Limits On Operating Costs of Inpatient Hospital Services and the Conclusive Application of the Limits are Valid

This is in response to your request, dated June 21, 1988, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC § 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the questions of whether the cost limits established under Medicare regulation, 42 CFR § 413.30 (formerly 42 CFR § 405.460), are valid and if the conclusive application of these limits is proper. The above-cited statutory provision permits a provider that has requested and is entitled to a hearing before the Board, under 42 USC § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation

where the Board determines that it is without authority to decide such question.

The Board has reviewed the Provider's submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $10,000 for each year and is as follow:

F/Y	Amount
September 30, 1980 –	$36,000
September 30, 1982 –	$59,000
September 30, 1983 –	$35,000

The estimated amounts in controversy, as shown, are subject to recalculation by the intermediary for the actual final amounts.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Provider is entitled to a hearing before the Board;
2. That based upon the Provider's assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR § 405.1867); and
4. That the Board is without authority to decide the legal questions of whether the cost limits established under Medicare regulation 42 CFR § 413.30 (formerly 42 CFR § 405.460) are valid and if the conclusive application of these limits is proper.

Accordingly, the Board finds that this case properly falls within the provisions of 42 USC § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the cost limits issue for the subject years. The Provider has 60 days from the date

of this decision to institute the appropriate action for judicial review.

Board Members Participating:
Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

/s/ Elise D. Smith
Elise D. Smith
Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended

JRB/tyw

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15772
D.C. No. CV 89-2714-DLJ

MT. DIABLO HOSPITAL, PLAINTIFF-APPELLANT,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Northern District of California
D. Lowell Jensen, District Judge, Presiding

No. 90-15857
D.C. No. CV 88-282-EDP

MEMORIAL HOSPITALS ASSOCIATION, PLAINTIFF-APPELLANT,

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Eastern District of California
Edward D. Price, District Judge, Presiding

Argued and Submitted
August 20, 1991—San Francisco, California
Filed April 28, 1992

Before: Dorothy W. Nelson, Cynthia Holcomb Hall, and Ferdinand F. Fernandez, Circuit Judges.

Per Curiam

COUNSEL

William Uhle, Thummel & Uhle, Portland, Oregon; John R. Faust, Jr., Mildred J. Carmack, Schwabe, Williamson & Wyatt, Portland, Oregon, for the plaintiff-appellants.

Charles H. Turner, United States Attorney, District of Oregon; Jennifer J. Martin, Special Assistant United States Attorney, Portland, Oregon, for the defendant-appellee.

OPINION

PER CURIAM:

Mt. Diablo and Memorial Hospitals appeal from the district courts' grants of appellee Secretary of Health and Human Services Louis Sullivan's ("Secretary") motions for summary judgment. We consider whether the district courts erred in concluding (1) that the Secretary's methods for determining routine cost limits for Medicare reimbursement are not arbitrary and capricious and (2) that the providers were not entitled to retroactive corrective adjustments to compensate them for the effects of those cost limits. For the reasons stated below, we affirm the judgment in *Memorial Hospitals v. Sullivan*, No. 90-15857, but reverse and remand the decision in *Mt. Diablo Hospital v. Sullivan*, No. 90-15772.

I

BACKGROUND

Appellants provide health care services to eligible aged and disabled persons under the Medicare program, 42 U.S.C. § 1395 et seq. For the cost years at issue in this case,[1] providers were reimbursed for daily routine service costs at a rate equivalent to the lesser of the "reasonable cost" of the services or the "customary charges" for the services. Appellants challenge the methods used by the Secretary to determine the "reasonable cost" of providing routine care.

In 1972, Congress amended the Medicare Act to give the Secretary broad discretion to define reasonable costs.[2] The amendments were motivated by the desire to contain costs arising from "variations in the efficiency of operation [and] the provision of amenities in plush surroundings." H.R. Rep. No. 231, 92nd Cong., 2d Sess., *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069 [hereinafter House Report]. Previously, providers had been reimbursed for their actual

[1] Memorial challenges the reimbursement it received for the fiscal year ending in 1980. Mt. Diablo challenges its reimbursement for the fiscal years ending in 1982 and 1983.

[2] 42 U.S.C. § 1395x(v)(1)(A) states;

> Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

incurred costs. The new regulations excluded "any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A).

In 1974, the Secretary began the yearly publication of a schedule of routine cost limits pursuant to the 1972 amendments. The schedules were based on factors the Secretary found "appropriate and practical," including types of services furnished, geographic area, and institutional size. The schedules categorized hospitals by the per capita income of the location area and by number of beds. In 1979, the Secretary began using a wage index to calculate the reasonable cost of labor. The index was based on reports of quarterly hospital wages made to the Bureau of Labor Statistics of the Department of Labor ("BLS"). The average wage for a geographic area was computed by dividing the total hospital wages paid in one year by the total number of hospital workers in the area. The index was then formulated by dividing the average local wage by the national average. The resulting index value for each area would reflect the wage level for that area relative to the national average. *See Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981,* 46 Fed. Reg. 33637, 33638-89 (June 30, 1981) [hereinafter *1981 Schedule of Limits*].

The BLS data was criticized for several perceived flaws, including its age and its failure to standardize for factors such as the variation in occupational mix and proportion of part-time workers. The data's effective assumption that all employees worked full-time was detrimental to areas that employed large numbers of part-time workers. Areas in which hospitals employed large numbers of part-time employees were determined to have lower costs per employee,

and consequently assigned lower index values, than areas in which hospitals had the same costs but a different mix of part-time and full-time workers. Commentators also noted a distorting effect from the inclusion of federal and state hospital wage data in the index. The Secretary defended the use of the BLS data, stating that the indices employed "the most reliable data available," *Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1980,* 45 Fed. Reg. 41868, 41871 (June 20, 1980).

In 1983, Congress ordered the Secretary to conduct a study to develop a wage index that accounted for the deficiencies in the BLS data. According to the Secretary, the group which eventually conducted the study concluded that the failure to account for part-time workers was the "most serious deficiency" in the BLS data. In 1986, the Secretary finally revised the index to distinguish between part-time and full-time employees.

For the cost years at issue in this case, which were governed by the pre-1986 indices, appellants' costs exceeded the routine cost limits. Each appealed to the Provider Reimbursement Review Board ("PRRB") as required under the Medicare Act, 42 U.S.C. § 1395oo(a). Memorial sought reimbursement for costs in excess of Medicare's routine cost limits. Mt. Diablo requested an order allowing it to go directly to federal court to challenge the cost limits. The PRRB determined that it had no power to determine the validity of the wage index and authorized the parties to seek judicial review in the district court under 42 U.S.C. § 1395oo(f)(1).

Memorial and Mt. Diablo filed suit in the district courts in May 1988 and July 1989, respectively. Memorial sought a retroactive corrective adjustment to its reimbursement based on the "errors" in the wage index or, alternatively,

an exemption from the routine cost limits on the grounds that the inaccurate wage index was "an extraordinary circumstance beyond its control."[3] Mt. Diablo sought both a declaration that the methodology used in calculating the area wage index was invalid and a retroactive corrective adjustment. The district courts granted the Secretary's motions for summary judgment in each case. Both hospitals timely appealed.

II

STANDARD OF REVIEW

We review the district court's grant of the Secretary's motion for summary judgment de novo. *Vallejo Gen. Hosp. v. Bowen,* 851 F.2d 229, 230-31 (9th Cir. 1988).

The Secretary's Medicare reimbursement policy is reviewed under the Administrative Procedure Act (APA), 42 U.S.C. § 1395oo(f)(1). Under the APA, we must determine if the Secretary's action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). In making this determination, we "must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 416 (1971).

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[3] There are two basic mechanisms for the adjustment of cost limits where the general rules do not adequately reimburse the health care provider for its reasonable costs—exemptions and retroactive corrective adjustments. All exemptions may be granted where, for example, excess expenses are attributable to provision of atypical services or "extraordinary circumstances." It will be allowed "only if the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the [the fiscal agent of the Secretary]." *Hennepin County v. Sullivan,* 883 F.2d 85, 87 (D.C. Cir. 1989), *cert. denied,* 493 U.S. 1043 (1990); 42 C.F.R. § 413.30(e), (f). Memorial does not appeal the denial of its request for an exemption.

III

ANALYSIS

A. Calculation of Cost Limits

Mt. Diablo argues that the pre-1986 method for calculating routine cost limits was arbitrary and capricious for two reasons. First, they contend that the Secretary ignored a relevant factor—the discrepancies in the wage index caused by regional variations in the use of part-time and full-time employees. Second, they argue that the Secretary failed to respond adequately to public comments on this issue.

1. Failure to consider a relevant factor.

Mt. Diablo points to three comments on the proposed use of the BLS data as evidence that the Secretary knew about and failed to consider the distortion caused by part-time workers.[4] In 1979, the Hospital Association of New York State (HANYS) commented: "A wage level comparison based upon [the BLS data relating to service workers] can be distorted by the regional variations in mix of part-time employment, hours worked per week, overtime

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[4] Mt. Diablo also points out that in the July 3, 1984, Federal Register the Secretary acknowledged that "the most serious deficiency" of the BLS data was its failure to control for part-time workers. *Health Care Financing Administration Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges on or After October 1, 1984, and Update Factors Effective with Cost Reporting Periods Beginning on or After October 1, 1984,* 49 Fed. Reg. 27438, 27439 (July 3, 1984). It relies upon the adoption in 1986 of a wage index accounting for part-time workers as further evidence of the rule's arbitrariness. Evidence of subsequent developments, however, is not considered in a review of informal agency rulemaking. Review is limited to the administrative record before the Secretary at the time of his decision. *See Citizens to Preserve Overton Park,* 401 U.S. at 420.

pay, etc." *Comments of the Hospital Association of New York State on the Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning On Or After July 1, 1979,* April 30, 1979, at 2 [hereinafter *Comments of HANYS*].[5]

In 1980, the Secretary received two additional comments on the wage index. The Hospital Association of Rhode Island advocated use of data from the American Hospital Association (AHA) because of the distortion caused by BLS' failure to account for part-time workers. An accounting firm also noted the impact of the omission, stating that "those areas with a large volume of part-time hospital workers will rate lower than areas with more full-time employment, even though their actual wage scales may be higher."

We review agency actions under the APA to determine if the agency has adequately considered all "relevant factors." *See Citizens to Preserve Overton Park,* 401 U.S. at 416. An agency rule may be found to be arbitrary and capricious when

> the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

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[5] However, HANYS also acknowledged:

> [T]here is, at the present time, no data source which is external to the hospital economy that can be used to reasonably adjust the differences between salaries. The development of such data certainly is possible but would involve considerable time, difficulty, and expense to develop.

Comments of HANYS, at 2.

Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983).

We may conclude that an agency has ignored relevant factors where its action amounts to an " 'artificial narrowing of options' [which] is antithetical to reasoned decision-making. . . ." *International Ladies' Garment Workers Union v. Donovan,* 722 F.2d 795, 817 (D.C. Cir. 1983) (quoting *Pillai v. Civil Aeronautics Bd.,* 485 F.2d 1018, 1027 (D.C. Cir. 1973)) (internal citation omitted). Agency actions cannot be sustained where the agency has failed to consider significant alternatives. *See ILGWU,* 722 F.2d at 815-16 (agency failed to consider "substantial testimony" and "specific proposals" for alternative actions). Similarly, an action will not be upheld where the agency has intentionally omitted evidence from consideration or where there is nothing in the record to support the agency's decision. *See Pillai,* 485 F.2d at 1027; *California Hosp. Ass'n v. Schweiker,* 559 F. Supp. 110 (C.D. Cal. 1982) (in drafting documents supporting a proposal, agency intentionally omitted facts which undermined its position), *aff'd,* 705 F.2d 466 (9th Cir. 1983).

Applying these criteria, we cannot conclude that the Secretary acted arbitrarily or capriciously by not factoring the use of part-time workers into the wage index. A relatively insignificant percentage of the comments received during the period leading up to the adoption of the 1981 routine cost limits were directed at the part-time worker issue. Most comments were directed at other concerns, particularly a fundamental change in the reimbursement rate and the proposed methods of classifying care providers. Additionally, the record suggests that, far from intentionally omitting the issue from consideration, the agency recognized the growing concern about the part-time worker issue and planned to address it in a comprehensive manner. Indeed, the agency proposed in 1981 to develop an appropriate database

by modifying the Medicare cost report, but the proposal was delayed in part because of opposition from the hospital industry.

Moreover, the agency's action was well within the reasonable bounds of its Congressional mandate. The agency was given broad powers to promulgate regulations providing for the determination of the costs of services, including the establishment of limits on costs to be recognized as reasonable. *See* 42 U.S.C. § 1395x(v)(1)(A). A court must accord an agency's statutory interpretation "substantial deference," since "presumably [the agency] has brought its expertise to bear in formulating the regulation. . . ." *American Hosp. Mgmt. Corp. v. Harris,* 638 F.2d 1208, 1212 (9th Cir. 1981). Review in such a case "is limited to determining whether the regulation is reasonably related to the purpose of the relevant enabling legislation. . . ." *Id.*

Here, Congress recognized that "the initial ceilings will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. . . . The data that are available for this purpose will often be less than perfectly reliable. . . ." House Report, *supra,* at 5070. To forbid the agency from adopting routine cost limits until perfect data concerning a relatively minor issue is developed would contravene the agency's mandate. This is particularly true in the case of part-time workers, since Congress had recognized the need for ongoing refinements and the agency had proposed to remedy the problem.

Mt. Diablo also argues that the Secretary should have used AHA data, which was weighted to account for the part-time worker issue, in formulating the wage index. It claims this data was available to the Secretary as early as 1979, and that it was used in calculating other portions of the wage index.

The Secretary did not indicate why (or whether) the BLS data was preferable to the AHA data with regard to the

part-time worker issue. But "we will uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned," *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.,* 419 U.S. 281, 286 (1974). That path is evident here. The record indicates that the decision to use the BLS data was based upon a number of factors, including variations in over-time, and variations in hospital occupational categories. The agency stated in the June 20, 1980, Federal Register that it did "not bas[e] the wage index on AHA data because these data are less complete than those supplied by the BLS, since they do not include all of the occupational categories comprised by the BLS data base." *Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs of Cost Reporting Periods Beginning on or after July 1, 1980.* 45 Fed. Reg. 41868, 41872 (1980). The agency simply chose one imperfect database over another while seeking to develop data superior to either. This choice was rational. The Secretary concluded that the BLS data were "the most reliable data available" at the time. *See Schedule of Limits, supra* at 33639. Given the narrow scope of review, we cannot regard the Secretary's decision to use that data as arbitrary and capricious.[6]

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[6] The Eighth Circuit has reached the same conclusion on similar facts. In *Good Samaritan Hosp. v. Sullivan,* 952 F.2d 1017 (8th Cir. 1991), rural Nebraska hospitals, which exceeded the Secretary's cost schedules, claimed that the wage-index regulations were arbitrary and capricious for failing to account for the use of part-time employees. Like appellants in this case, the hospitals claimed that the Secretary knew of the distortion but did nothing to correct it. The Eighth Circuit rejected the hospitals' claim, holding:

> At the time the regulations were in place, the Secretary claims that they were based upon the latest available data. There is nothing arbitrary or capricious about the cost limit methodology used by the Secretary. Both the wage index and the rural/urban distinction were based on objective data and regulations, and we hold the SMSA-based cost limit regulations are not arbitrary or capricious.

Id. at 1025 (citations omitted).

2. Failure to respond adequately to public comments.

Mt. Diablo argues that the routine cost limits are invalid because the Secretary "did not respond specifically" in the Federal Register to comments about the part-time worker issue. The Secretary explained his use of the BLS data only by saying that they were "the most reliable data available." *See Schedule of Limits, supra* at 33639. Mt. Diablo contends that the Secretary was obligated to explain the reasoning behind that conclusion.

A rule may be invalidated under the APA because an agency fails to explain the rule adequately. *United States v. Garner,* 767 F.2d 104, 117 (5th Cir. 1985); *see also International Bhd. of Teamsters v. United States,* 735 F.2d 1525, 1532 (D.C. Cir. 1984) (in absence of "*other* indication" of why the agency acted as it did, "bald assertion" that reporting items are "unnecessary" cannot be upheld). Nevertheless,

> [t]here is no obligation to make references in the agency explanation to all the specific issues raised in comments. The agency's explanation must simply enable a reviewing court to see what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them the way it did.

South Carolina ex rel. Tindal v. Block, 717 F.2d 874, 886 (4th Cir. 1983) (internal citations and quotations omitted), *cert. denied,* 465 U.S. 1080 (1984). In making the "keystone" inquiry whether the Secretary "engaged in reasoned decision-making," *ILGWU,* 722 F.2d at 815, the reviewing court is to consider the larger administrative record. 5 U.S.C. § 706.

As the preceding discussion explains, the record indicates that the Secretary acted reasonably in formulating the wage index. Moreover, given the fact that the part-time worker

issue was of minor significance at the time the wage index was adopted, the Secretary had no obligation to provide a specific response to the comments about it. The Secretary's general response to the concern over the validity of the BLS data was appropriate.

B. Retroactive Corrective Adjustments

The Medicare statute, 42 U.S.C. § 1395, requires the Secretary to make "retroactive corrective adjustments" for hospitals whose reimbursement under the cost rules "proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii). Mt. Diablo and Memorial hospitals seek a retroactive corrective adjustment because they claim that the old cost rules undercompensated them by failing adequating to take into account their labor costs. The district courts denied relief on different grounds.

The statute at issue, 42 U.S.C. § 1395x(v)(1)(A), provides that "[t]he reasonable cost of any services . . . shall be determined in accordance with regulations establishing the method or methods to be used . . . in determining such costs. . . . Such regulations shall . . . (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." On its face, the plain language of the statute appears to require the Secretary to make a retroactive adjustment when its cost method produces an inequitable result in a particular case.

In *Regents of the Univ. of California v. Heckler,* 771 F.2d 1182, 1189 (9th Cir. 1985), the Secretary contended that this provision requires "no more than a year-end balancing of the books." *Id.* at 1189. We rejected that argument for four reasons. First, such a limited reading was inconsistent with the plain language of the statute, which requires adjustments whenever a hospital's compensation is "inadequate or ex-

cessive," not merely when it has been calculated incorrectly. *Id.* at 1189-90. Second, a different section—42 U.S.C. § 1395(g)—already provides for a year-end adjustment to rectify accounting errors made in calculating the cost reimbursements. To read section 1395x(v)(1)(A)(ii) as requiring nothing more would make it redundant. *Regents,* 771 F.2d at 1189.

Third, the 1972 Medicare amendments, which established the cost methods at issue in *Regents* and here, "merely added another method of cost calculation to those already recognized as legitimate by the statute." *Id.* Prior methods had already been determined to be subject to the provisions for retroactive adjustment. To conclude that this new method was immune from retroactive adjustments on the basis of inadequate reimbursement would lead to the perverse result of "render[ing] the corrective adjustment clause nugatory in the case of one particular method of calculating costs." *Id.* at 1190. Finally, *Regents* reviewed the legislative history of the section, which seemed unambiguously to establish that the Secretary's cost limits were *presumptive,* not conclusive, *Id.*. Thus, *Regents* concluded that hospitals were entitled to seek a retroactive corrective adjustment on the grounds that the cost limits, *even though correctly applied,* worked an injustice in their particular circumstance. *Id.* at 1191.

Under *Regents*, the hospitals are entitled to make their case for a retroactive corrective adjustment. The only question in this case is whether *Regents* remains good law after the Supreme Court's decision in *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988), which also applied section 1395x(v)(1)(A)(ii).

In *Georgetown,* the Secretary's 1981 cost rule had been struck down by a court, and the Secretary sought to reimpose the rule retroactively and collect the "overpayments" it had made to *all* hospitals during the time the rule had

been held invalid. The Supreme Court rejected the Secretary's argument, holding:

> This provision [1395x(v)(1)(A)(ii)] on its face permits some form of retroactive action. We cannot accept the Secretary's argument, however, that it provides authority for the retroactive promulgation of cost-limit rules. To the contrary, we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking.

Id. at 209. In so doing, *Georgetown* cited *Regents* with apparent approval, distinguishing it from those cases which had permitted the Secretary to engage in retroactive rulemaking. *Id.* at 209-10 n.1.[7]

Thus, the rule established by the Supreme Court in *Georgetown* is that case-by-case adjustments in the interests of justice are allowed under clause (ii), but rules of general applicability are not. The only question, therefore, is whether what Mt. Diablo and Memorial are seeking constitutes across-the-board rulemaking or a case-by-case adjustment. It seems clear that they intended to seek the latter. In fact, the district courts in both cases recognized that

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[7] Regarding *Regents,* the Supreme Court had this to say: "Other courts, without deciding whether clause (ii) permits rulemaking, have held that it requires the Secretary to make case-by-case adjustments to reimbursement determinations. *E.g.,* . . . *Regents of the University of California v. Heckler,* 771 F.2d 1182, 1188-89 (CA9 1985)." *Georgetown,* 488 U.S. at 210 n.1.

the hospitals were seeking individualized adjustments to the aggregate amount of their reimbursement under clause (ii), not revisions in the cost methods used by the Secretary.[8]

The Secretary suggests that, notwithstanding the hospitals' characterization of their own claim, they really seek rulemaking changes. We do not agree. Unlike the Secretary's proposed changes in *Georgetown*, which would affect all hospitals under the rules, the adjustments sought by Mt. Diablo and Memorial would apply only to them. The situation of the hospitals is similar to the situation in *Regents*: the hospital there was entitled to seek reimbursement under clause (ii) over and above the cost limits imposed by the Secretary, even though its claims were based on exceptions the Secretary had already determined not to apply. *See Regents,* 771 F.2d at 1185-86. Both the facts of this case and Ninth Circuit precedent suggest that what the hospitals are seeking here is a case-by-case adjustment, not retroactive rulemaking.[9]

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[8] Both hospitals *also* sought changes in the Secretary's cost methods; those claims are dealt with in Part III.A, *ante*. There is nothing in the Medicare statute which prohibits hospitals from seeking both a general change in the law and a specific adjustment for their particularlized circumstances.

[9] The Eighth Circuit has concluded in a very similar case that what the hospitals are seeking really constitutes rulemaking. *Good Samaritan Hospital v. Sullivan,* 952 F.2d 1017, 1023-24 (8th Cir. 1991); *see also Hennepin County v. Sullivan,* 883 F.2d 85, 92-93 (D.C. Cir. 1989) (stating same in dictum; parties conceded the issue at oral argument), *cert. denied,* 493 U.S. 1043 (1990). However, the conclusion in both those cases was based on the determination that "clause (ii) merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Good Samaritan,* 952 F.2d at 1024; *See Hennepin,* 883 F.2d at 93 (clause (ii) allows only review of accounting calculations). As noted above, this Circuit has *expressly* rejected that view for a number of sound reasons, *see Regents,* 771 F.2d at 1189, and nothing in *Georgetown* even intimates that clause (ii) is merely an accounting provision.

We therefore conclude that the hospitals are entitled to make a showing that their compensation was inadequate and that they are entitled to a retroactive adjustment awarding them their "reasonable" costs in excess of the limits prescribed by the Secretary. We remand the Mt. Diablo case to the district court to permit Mt. Diablo to make the required showing.

We do not need to remand the Memorial case, however. The district court in that case did not decide that *Georgetown* overruled *Regents,* but rather concluded that Memorial had not made a factual showing sufficient to entitle it to relief under clause (ii) because it could not demonstrate that its costs were reasonable. Memorial did not challenge that finding before this court, except to argue that the fact that the Secretary subsequently changed the cost limits automatically rendered its costs reasonable. We reject this argument for the reasons already discussed. The fact that under *Regents* hospitals *may* be entitled to retroactive corrective adjustments does not absolve them of the responsibility of proving that they *are* entitled to such adjustments in any particular case.

IV

CONCLUSION

We conclude that the Secretary's method for calculating routine cost limits for Medicare reimbursement was not rendered arbitrary and capricious by the Secretary's failure to account for the use of part-time workers. We also conclude that hospitals are entitled to seek a retroactive adjustment to the wage index to account for the use of part-time workers. The decision of the district court in docket No. 90-15857, *Memorial Hospitals Ass'n v. Sullivan,* is AFFIRMED. The decision of the district court in docket No. 90-15772, *Mt. Diablo Hospital v. Sullivan,* is REVERSED and REMANDED.

42 U.S.C. § 1395x(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take

into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

Supreme Court, U.S.
FILED
SEP 11 1992
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No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS

v.

LOUIS M. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Under the Medicare program, health care providers are reimbursed by the government for expenses incurred in providing medical services to Medicare beneficiaries. Under Part A of the Medicare program, providers are reimbursed for either their "customary charge" or the "reasonable costs" of the services, whichever is less. Congress has granted the Secretary authority to adopt methods for determining costs, and to establish cost limits. 42 U.S.C. 1395x(v)(1)(A). Congress has also directed the Secretary to promulgate regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) (clause (ii)). The Secretary has promulgated regulations providing for exceptions to and exemptions from the cost limits in specified circumstances. The question presented is:

Whether a health care provider may obtain additional reimbursement under clause (ii) in excess of the cost limits established by the Secretary even if the provider does not qualify for an exception or exemption under the Secretary's regulations.

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v.

LOUIS M. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-17a) is reported at 952 F.2d 1017. The opinion of the district court (Pet. App. 19a-36a) is reported at [Oct. 1989-Sept. 1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,400. The decisions of the Provider Reimbursement Review Board (Pet. App. 37a-54a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. On February 7, 1992, the court of appeals denied a petition for rehearing. Pet. App. 18a. On April 28, 1992, Justice Blackmun granted an

extension of time to file a petition for a writ of certiorari to and including July 6, 1992. The petition for a writ of certiorari was filed June 26, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. The Medicare program, 42 U.S.C. 1395 *et seq.*, provides for payment of medical expenses for eligible aged and disabled persons. Part A of the Medicare program (Hospital Insurance Benefits) authorizes payment for primary institutional care to providers of services, including hospitals, skilled nursing facilities, and home health agencies. See 42 U.S.C. 1395c to 1395i-3 (1988 & Supp. II 1990).

For the years at issue in this case, Part A providers were reimbursed for the "customary charges" for the services furnished or the "reasonable cost" of the services, whichever was less. 42 U.S.C. 1395f(b)(1).[1] The Medicare statute defines "rea-sonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and directs the Secretary to promulgate regulations establishing the method or methods for determining reasonable cost. 42 U.S.C. 1395x(v)(1)(A). The statute also directs the Secretary to promulgate regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) [hereinafter clause (ii)].

[1] Beginning on October 1, 1983, most Part A Medicare claims for hospital inpatient services are reimbursed in accordance with prospectively determined rates under the Prospective Payment System. See 42 U.S.C. 1395ww(d) (1988 & Supp. II 1990); 42 C.F.R. Pt. 412 (1991).

Congress became concerned that, in practice, "reasonable cost" reimbursement allowed providers to recover whatever costs they incurred. H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-85 (1971); S. Rep. No. 1230, 92d Cong., 2d Sess. 188-189 (1972). In 1972, Congress responded to this problem by authorizing the Secretary to promulgate regulations establishing cost limits that would "be recognized as reasonable." Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1393-1394. In 1974, the Secretary promulgated regulations establishing cost limits for certain items and services furnished by providers. See 20 C.F.R. 405.460 (1975), redesignated as 42 C.F.R. 413.30 (1991). The regulations establish a presumption that reimbursable costs may not exceed the applicable cost limits. 42 C.F.R. 413.30(a)(2). The regulations also specify circumstances in which providers may obtain reimbursement in excess of the applicable cost limits. Thus, exemption from the cost limits may be granted to certain providers, such as new providers, sole community hospitals, and small rural hospitals. 42 C.F.R. 413.30(e). In addition, exceptions may be granted in certain situations, such as those involving atypical services, extraordinary circumstances beyond the provider's control, or essential community hospital services. 42 C.F.R. 413.30(f).

b. For the cost years at issue in this case, the Secretary classified providers according to two criteria: (1) an area wage index; and (2) location within or without a Standard Metropolitan Statistical Area (SMSA). The Secretary adopted a wage index in 1979 to "adjust[] for variations in wage levels" among geo-

graphical areas. 44 Fed. Reg. 11,613 (1979). Initially, the Secretary relied on wage data from the Bureau of Labor Statistics (BLS). *Ibid.* But the BLS data were criticized because, among other things, they failed to account for local variations in the proportion of part-time to full-time workers.

In 1984, Congress directed the Secretary to conduct a wage index study to adjust for variations in part-time employees. Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081. Based on data obtained from that study, the Secretary revised the wage index in 1986 to account for part-time employees. 51 Fed. Reg. 16,772 (1986). Congress provided that the revised index would be applicable only to patient discharges occurring on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156.

In 1974, the Secretary decided to use location within an SMSA "as a proxy for an urban location"; locations not within an SMSA "are considered nonurban" or rural. 39 Fed. Reg. 20,168 (1974). Since it is generally "more expensive to operate a hospital in an urban area than in a rural area" (44 Fed. Reg. at 11,613), the cost limit for providers within an SMSA is higher than the cost limit for providers outside of an SMSA. In accordance with the prospective nature of the cost limit regulations, changes to SMSA designations apply only to fiscal years following the effective date of the change. Cf. 49 Fed. Reg. 34,728, 34,736 (1984).

2. a. Petitioners are six rural Nebraska hospitals that exceeded the Secretary's cost limits for some of the years between 1980 to 1984. Petitioners challenged the cost limits and also sought a "suitable

retroactive corrective adjustment[]" under clause (ii) before the Secretary's Provider Reimbursement Review Board. Petitioners contended, *inter alia*, that the cost limits did not properly account for the high proportion of part-time employees in their work force and did not permit rural hospitals to show that they incurred costs similar to those of urban hospitals. The Review Board, which is bound by the Secretary's regulations, determined that it lacked authority over petitioners' legal challenges and granted their requests for expedited judicial review. Pet. App. 37a-54a; 42 U.S.C. 1395*oo*(f)(1).[2]

b. The district court concluded that "the Secretary must * * * allow [petitioners] an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined reasonable under the cost limit schedule." Pet. App. 26a. Applying the court of appeals' decision in *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (8th Cir. 1987), the district court held that "[t]he Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs." Pet. App. 29a. The court rejected

[2] The Review Board also concluded that it lacked jurisdiction over the claims of petitioners Memorial Hospital (Seward), Memorial Hospital of Dodge County, and St. Mary's Hospital for three cost years because those petitioners had not filed timely individual appeals for those years. Pet. 5 & n.1. In addition, the Health Care Financing Administration (HCFA) rejected a claim by petitioner Memorial Community Hospital that it should be reclassified as an "urban" rather than a "rural" hospital for purposes of the cost limits. Pet. 5. Both the district court (Pet. App. 33a-35a) and the court of appeals (*id.* at 15a-16a) upheld these determinations; petitioners do not challenge them here. Pet. 7 n.2.

the Secretary's argument that clause (ii) "only authorizes a year-end 'book balancing' adjustment" to ensure "that the provider receives what is due under the cost limits as applied." Pet. App. 27a-28a. The district court remanded the case to the Secretary for "consideration of [petitioners'] reasonable expenses in excess of the cost limit rules in effect for the years under appeal." *Id.* at 32a.

3. The court of appeals reversed. Pet. App. 1a-17a.[3] The panel agreed with the Secretary that the Eighth Circuit's prior interpretation of clause (ii) in *St. Paul-Ramsey* was effectively overruled by this Court in *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). Pet. App. 11a. Under *Georgetown*, the panel explained, "clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts" disbursed to a provider. *Id.* at 12a. Accordingly, clause (ii) "merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." Pet. App. 12a. The court rejected petitioners' claims for additional reimbursement under clause (ii), holding that the relief they sought "would amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown*, is invalid." Pet. App. 13a. Such a methodological change would constitute a "second bite at the apple" on claims for reimbursable costs, a result that clause (ii) "does not allow." Pet. App. 13a-14a (citing *Hennepin County* v. *Sullivan*,

[3] As an initial matter, the court of appeals dismissed the appeal of petitioner Mary Lanning Memorial Hospital for lack of jurisdiction under *Torres* v. *Oakland Scavenger Co.*, 487 U.S. 312 (1988). Pet. App. 8a-11a. Petitioners (including Mary Lanning) were appellees as to the question presented in the petition. Consequently, the jurisdictional issue does not arise in this Court.

883 F.2d 85, 92 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990), and *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990)). The court of appeals upheld both the wage index and the SMSA-based cost limit regulations against petitioners' challenges, concluding that "[t]here is nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a.

ARGUMENT

Petitioners exceeded the Secretary's cost limits for the years at issue, and they concede (Pet. App. 4a n.4) that they are not entitled to reimbursement in excess of those limits under any exception or exemption established by regulation. Petitioners nevertheless contend that clause (ii) requires the Secretary to make an ad hoc determination whether additional reimbursement in excess of the cost limits is reasonable in this case. The court of appeals correctly rejected that contention. As petitioners note, however, the court of appeals' decision conflicts with the Ninth Circuit's recent decision in *Mt. Diablo Hosp.* v. *Sullivan*, 963 F.2d 1175 (1992). Because the question presented is of considerable practical importance, we do not oppose the granting of certiorari in this case.[4]

1. a. In *Bowen* v. *Georgetown Univ. Hosp.*, *supra*, this Court held that clause (ii) does not authorize the Secretary to adopt retroactive cost limits. The Court applied the rule that "congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this

[4] On July 24, 1992, the Ninth Circuit denied the government's petition for rehearing and suggestion of rehearing en banc in *Mt. Diablo*. The Solicitor General has authorized the filing of a petition for a writ of certiorari in that case.

result." 488 U.S. at 208. The Court observed that clause (i) of Section 1395x(v)(1)(A), which authorizes the Secretary to establish cost limit methods, speaks of "providers," while clause (ii), which governs retroactive adjustments, speaks of "*a provider*." 488 U.S. at 210. The Court reasoned:

> The distinction suggests that clause (ii), rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers. * * *
>
> * * * * *
>
> It is also significant that clause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. As the Secretary concedes, the cost-limit rules are one of the methods of determining costs, and the retroactive 1984 rule was therefore an attempt to change one of those methods. Yet nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

488 U.S. at 210-211. The Court illustrated the distinction between a retroactive change in methods and adjustments to the aggregate amount of reimbursement due under the Secretary's pre-existing methods by citing the Secretary's regulations authorizing adjustments for individual providers "in accordance with an accepted method of cost apportionment." *Id.* at 211-212 & n.2.

In sum, clause (ii), as construed by this Court in *Georgetown*, provides for a year-end adjustment within the framework of the Secretary's cost limit rules and regulations. It does not require the Secretary to make an ad hoc inquiry into the reasonableness of an individual provider's costs without regard to whether the provider has exceeded the applicable cost limits or met the regulatory criteria for an exception or exemption. Such a requirement would greatly undermine the utility of cost limits of general applicability in the vast Medicare program.[5]

b. Petitioners argue (Pet. 11) that they sought only "an individual adjustment to their reimbursement because the cost limits methodology was applied to them in a conclusive fashion, rather than in a presumptive manner," resulting in "inadequate reimbursement of their reasonable costs." Petitioners also contend (*ibid.*) that the court of appeals improperly characterized their claims as "tantamount to a retroactive change in the cost limits rules * * * prohibited by *Georgetown*" and ignored the "dichotomy recognized in *Georgetown* between case-by-case [retroactive] adjudications resulting in adjustments to individual providers[] * * * and across-the-board [prospective] rulemaking by the Secretary." Petitioners' arguments are unconvincing.

[5] The court of appeals' construction of clause (ii) is in accord with the relevant evidence of legislative intent. The 1972 amendments to the Medicare statute were intended to give providers incentives to operate efficiently and reduce Medicare costs. H.R. Rep. No. 231, *supra*, at 82-85. Petitioners' construction of clause (ii) would undermine those incentives by encouraging providers to seek additional reimbursement whenever their costs exceed the Secretary's cost limits.

First, contrary to petitioners' suggestion, the Secretary's cost method rules are presumptive rather than conclusive. As noted above (p. 3, *supra*), providers may rebut the presumption that their costs are unreasonably high by showing that they meet the requirements for an exemption or exception established by regulation. Petitioners concede that they do not qualify for such relief. Nor does the court of appeals' holding deprive petitioners of their right to challenge the Secretary's cost method rules. Indeed, petitioners raised such a challenge in this case, and the court of appeals rejected it on the merits—a holding that petitioners no longer dispute. Pet. App. 14a-15a; see also *id.* at 61a-67a. Having failed in their direct legal challenge, petitioners seek to use clause (ii) to change the Secretary's "methodology * * * to correct what they believe are inequalities in the system." Pet. App. 13a. The court of appeals correctly held that clause (ii) does not furnish a means by which petitioners may obtain "a second bite at the apple." Pet. App. 14a.

2. Petitioners correctly observe (Pet. 7-10) that the courts of appeals are in conflict as to the meaning of clause (ii). The District of Columbia Circuit agrees with the Eighth Circuit that clause (ii) does not "compel the Government, after the fact, to consider whether, as a matter of 'fairness,' claimants should be awarded something more than lawful regulations required. * * * [T]he clause does not authorize a post hoc reassessment of the efficacy of the relevant standard, only of the calculations made pursuant to that standard." *Hennepin County* v. *Sullivan*, 883 F.2d 85, 93 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990). Cf. *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990) (clause (ii) "does not permit HHS to change the *methods* used," but rather

"permits HHS to adjust the *aggregate amounts* of reimbursement that applying those methods produced"). In contrast, the Ninth Circuit in *Mt. Diablo Hosp.* v. *Sullivan*, 963 F.2d 1175 (1992), has rejected that approach and held that "hospitals are entitled to make a showing that their compensation was inadequate and that they are entitled to a retroactive adjustment awarding them * * * 'reasonable' costs in excess of the limits prescribed by the Secretary."[6] *Id.* at 1183. See note 4, *supra*.

As noted above, see note 1, *supra*, Congress has adopted a new Prospective Payment System that governs provider reimbursement for most hospital inpatient services provided since October 1983. Although this change reduces the long-term significance of the question presented in this case, the

[6] Prior to this Court's decision in *Georgetown*, the courts of appeals did not agree on the interpretation of clause (ii). *See, e.g.*, *Medical Center Hosp.* v. *Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the Univ. of Cal.* v. *Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Daughters of Miriam Center for the Aged* v. *Mathews*, 590 F.2d 1250 (3d Cir. 1978); *Springdale Convalescent Center* v. *Mathews*, 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973). This pre-*Georgetown* conflict, standing alone, would not warrant certiorari. The decision in this case demonstrates that the courts of appeals are capable of changing their views on this issue in light of *Georgetown*. There now is, however, a post-*Georgetown* circuit conflict on the meaning of clause (ii).

Petitioners also assert that the Secretary has acted inconsistently under clause (ii), citing it "as authority for numerous other actions apart from year-end book-balancing or retroactive rulemaking." Pet. 8 n.3 (collecting authorities). To the extent that the Secretary advocated other positions concerning clause (ii) prior to *Georgetown*, he has now conformed his view of clause (ii) to the Court's decision in that case.

question nonetheless continues to have considerable practical importance. The Secretary's cost limits continue to apply to skilled nursing facilities and home health agencies. HCFA informs us that 6,211 skilled nursing facilities and 6,009 home health agencies participate in the Medicare program. Those providers receive $7.65 billion annually in Medicare payments, and HCFA estimates that approximately $400 million in claims are disallowed each year as a result of the cost limits. In addition, 2,832 hospitals are excluded from the Prospective Payment System and instead are subject to rate-of-increase limits under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), 42 U.S.C. 1395ww(b) (1988 & Supp. II 1990), that are similar to the Secretary's cost limits. See 42 C.F.R. 412.22-412.23 (1991). The question presented in this case may affect those hospitals as well. The sheer number of providers affected, as well as the significant amounts of money at stake, reflect the continuing importance of the issue.

In view of the conflict in the courts of appeals, and the importance of the question presented, we do not oppose the petition for a writ of certiorari in this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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SEPTEMBER 1992

FILED
NOV 25 1992
OFFICE OF THE CLERK

(3)

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED JUNE 26, 1992
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Memorandum and Order on Cross-Motions for Summary Judgment in *Good Samaritan Hospital, et al. v. Sullivan,* (D. Neb. Feb. 16, 1990)	Pet. App. 19a-36a
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CHRONOLOGICAL LIST OF RELEVANT
U.S. DISTRICT COURT DOCKET ENTRIES FOR
GOOD SAMARITAN HOSPITAL, ET AL. v. BOWEN,

Case No. CV 88-L-523 (D. NEB.)

Sept. 21, 1988—Complaint with attachments filed in U.S. District Court for the District of Nebraska.

Nov. 15, 1988—Amended complaint with attachments.

Dec. 22, 1988—Answer to amended complaint.

Feb. 16, 1990—Memorandum and Order on Plaintiffs' motion for summary judgment and Defendant's motion for summary judgment.

Feb. 16, 1990—Judgment for Plaintiffs on certain issues and for Defendant on certain issues. Case remanded to Secretary.

Apr. 13, 1990—Notice of appeal by Plaintiffs.

Apr. 16, 1990—Notice of appeal by Defendant.

CHRONOLOGICAL LIST OF RELEVANT
EIGHTH CIRCUIT DOCKET ENTRIES FOR
GOOD SAMARITAN HOSPITAL, ET AL. v. SULLIVAN,

Case Nos. 90-1641NE and 90-1642NE

Dec. 30, 1991—Opinion. Judgment of the District Court is affirmed in part and reversed in part.

Jan. 13, 1992—Appellants' petition for rehearing with suggestion for rehearing en banc.

Feb. 7, 1992—Order. The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA
LINCOLN DIVISION

Civil Action No. 88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D., SECRETARY OF
HEALTH AND HUMAN SERVICES, DEFENDANT.

[FILED NOV. 16, 1988]

AMENDED COMPLAINT FOR DECLARATORY RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

Plaintiffs, for their causes of action, allege as follows:

PARTIES

1. Plaintiffs (hereinafter "providers" or "hospitals") are licensed as general acute care hospitals by the State of Nebraska and are certified as "providers" of hospital health services under Title XVIII of the Social Security Act, as amended, Health Insurance for the Aged and Disabled. 42 U.S.C. §§ 1395 *et seq.*

2. Defendant Otis R. Bowen, M.D., (hereinafter "Secretary") is the Secretary of Health and Human Services, and as such is responsible for the administration of the Department of Health and Human Services (HHS or

Department), including the Medicare Program. The Health Care Financing Administration (HCFA) is the operating component of HHS charged with administration of the Medicare program.

JURISDICTION AND VENUE

3. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (1974 and Supp. 1982); the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983); the Administrative Procedure Act, 5 U.S.C. §§ 553 and 706; the Declaratory Judgment Act, 28 U.S.C. § 2201; the Fifth Amendment to the United States Constitution; and 28 U.S.C. § 1361.

4. Jurisdiction is grounded in 42 U.S.C. § 1395oo(f)(1).

5. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f) (1).

THE MEDICARE STATUTORY AND REGULATORY FRAMEWORK

6. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as "Medicare". 42 U.S.C. §§ 1395-1395ccc.

7. To participate in the Medicare program, a hospital must file a "provider agreement" with the Secretary of Health and Human Services, pursuant to 42 U.S.C. § 1395cc. A provider receives reimbursement from Medicare for services to Medicare beneficiaries. For a provider's fiscal years beginning before October 1, 1983, reimbursement was based upon the "reasonable cost" of such services. 42 U.S.C. § 1395f(b) (1) (A). "Reasonable cost" is defined as the "cost actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v) (1) (A).

8. In 1972 Congress amended § 1395x(v) (1) (A) of the Social Security Act to authorize the Secretary to establish limits on costs reimbursable under Medicare, based upon estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the Medicare program. 42 U.S.C. § 1395x(v) (1) (A), as amended by Pub. L. 96-203, § 223. In issuing such cost limitation regulations, the Secretary is required by statute to utilize a cost determination method which does not shift onto non-Medicare payors the necessary costs of the efficient delivery of services to Medicare-eligible individuals. 42 U.S.C. § 1395x(v) (1) (A) (i). The Secretary is also required to provide a system for making retroactive corrective adjustments for reimbursement of particular providers where the method of determining costs results in inadequate reimbursement. 42 U.S.C. § 1395x(v) (1) (A) (ii).

9. Congress intended the establishment of any cost limits on Medicare reimbursement pursuant to the 1972 Amendments to be for the purposes of curbing excessive costs not necessary in the delivery of health services and of preventing Medicare payments for luxurious accommodations or services. H.R. 92-231, 92d Cong., 2d Sess., May 26, 1971; S.R. No. 92-1230, 92d Cong. 2d Sess., Sept. 26, 1972. Congress also intended that the cost limits would be applied on a presumptive, not a conclusive, basis, and that providers would have an opportunity to demonstrate the reasonableness of their costs in excess of the limits. *Id.*

10. The Medicare routine cost limits regulation, 42 C.F.R. § 405.460, was first issued by the Department in 1974 in response to the 1972 Amendments to the Social Security Act. On June 1, 1979 the Department published amendments to the Medicare cost limits regulation, 42 C.F.R. § 405.460. 44 Fed. Reg. 31802. (The cost limits regulation has been recodified at 42 C.F.R. § 413.30 (1986), 51 Fed. Reg. 34793.)

11. In furtherance of and as an extension of the cost limits regulation, the Department has published schedules of per diem limits on hospital inpatient general routine operating costs. Schedules relevant to this action were issued in "final" by the Department on June 1, 1979, 44 Fed. Reg. 31806; on August 9, 1979, 44 Fed. Reg. 46949; on June 20, 1980, 45 Fed. Reg. 41868; on June 30, 1981, 46 Fed. Reg. 33637; on September 30, 1981, 46 Fed. Reg. 48010; on September 30, 1982, 47 Fed. Reg. 43282, and on August 30, 1983, 48 Fed. Reg. 39426. Other relevant publications of the Department were issuances of proposed schedules, and adjustments to these final schedules.

12. As noted by the Department in the text of each publication of the proposed and final hospital cost limits schedules for the 1979-1983 period, HCFA utilized a wage index prepared by the Bureau of Labor Statistics (BLS) according to HCFA specifications.

13. The employee wage data utilized by BLS as the statistical base to compute the wage indexes were incomplete and inexact because the data were for total wages and total number of employees from an area, without adjustment for full-time or part-time employee status. HCFA has admitted that the data used to compute the BLS wage index is not controlled for variations in full-time equivalency.

14. Failure to adjust this Medicare wage index for full time employee equivalency resulted in a disproportionately low index assigned to states with high part-time employee use.

15. At the time the Department published the hospital cost limits schedule in the 1979-1983 period, it knew or should have known that the wage index was unfair, inequitable, statistically invalid and contrary to law, due to its failure to distinguish between full and part-time employment.

16. No exception is available under the cost limits regulation by which a hospital can have the BLS-computed wage index recalculated to adjust for part-time employee use.

17. In 1984, Congress instructed the Secretary to revise the wage index to reflect the use of part-time employees. Pub. L. 98-369, § 2316(a). The defendant developed a revised wage index based upon actual hospital wage and employment data. 50 Fed. Reg. 24375 (June 10, 1985). This revision substantially raised the wage index in those areas with high proportions of part-time employees. HCFA did not apply the revised wage index retroactively.

18. The hospital cost limits schedule for the 1979-1983 period classified hospital providers as located in either urban or rural areas, based upon whether the location of the provider was inside or outside Standard Metropolitan Statistical Areas ("SMSAs") as defined by the Office of Management and Budget ("OMB"). OMB is not a component part of HHS and OMB has no statutory authority under the Social Security Act to administer the Medicare program. The SMSAs designated by OMB were not determined based upon studies specific to the delivery of health services in the United States generally, nor the delivery of health services by hospital providers under Medicare in particular.

19. The Medicare wage indices for urban hospitals within a given state are uniformly significantly higher than the wage index assigned to all rural hospitals in the same state.

20. According to HCFA regulations and practice, no exception is or has been available under the Medicare cost limits regulation for a hospital located outside an SMSA to be reclassified and reimbursed on a SMSA level, even if the hospital can demonstrate costs comparable to SMSA level hospitals. On this basis, plaintiffs Memorial Community Hospital, Memorial Hospital of Dodge County and Mary Lanning Memorial Hospital were denied requests for such reclassification by HCFA.

21. At the time the Medicare cost limits regulation was amended in 1979 and at the time the hospital inpatient cost limits schedules were issued for the periods 1979-1983, the Department knew or should have known that the SMSA/non-SMSA classifications applied to Medicare reimbursement were unfair, were based on inadequate or inappropriate information or statistical bases, and were contrary to law.

22. To produce the hospital cost limits schedules published during the 1979-1982 period, HCFA and BLS did not use then-current hospital data to create either the labor and non-labor components for the per diem rates or the wage index listings for the rural and SMSA areas. The data base from which averages were calculated was at least two years older than the period to which the resulting cost limits were made applicable.

23. No exception process is available under the cost limits regulation by which plaintiffs can obtain a cost limit adjustment to offset the adverse effects of the Department's reliance on stale employee data.

24. In promulgating the hospital cost limits schedules in 1980 the Secretary improperly sought to achieve overall budgetary controls on Medicare expenditures, rather than to curb hospital costs for reasons authorized under the statute, that is: cost demonstrated to be excessive for the necessary delivery of needed health services, or expended for luxurious items or services.

25. Payment to providers of Medicare services is either made directly or through fiscal intermediaries pursuant to contract with the Secretary. 42 U.S.C. § 1395h. Providers receive periodic interim payments, subject to adjustment for overpayment or underpayment. 42 U.S.C. § 1395g.

After the close of its fiscal year, a provider of services submits a "cost report" reflecting costs incurred during the fiscal year and an apportionment of those costs between Medicare and non-Medicare patients. After audit, the intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit. This final determination is the Notice of Program Reimbursement. 42 C.F.R. § 405.1803. A provider may file an appeal at the Provider Reimbursement Review Board within 180 days of receipt of its NPR to contest any issue relating to its reimbursement. 42 U.S.C. § 1395oo(a).

FACTS RELATING TO PLAINTIFFS

26. During the cost years at issue, each plaintiff had a provider agreement with the Secretary for the provision of Medicare services.

27. During the cost years at issue, the local fiscal intermediary for all of the plaintiff hospitals was Blue Cross of Nebraska under a subcontract with Blue Cross and Blue Shield Association.

28. Each plaintiff filed a timely cost report with the local fiscal intermediary, Blue Cross/Nebraska, for each fiscal year under appeal.

29. Each plaintiff filed a timely request for a hearing before the Board for each cost reporting period under appeal.

30. Plaintiffs Memorial Community Hospital, Memorial Hospital of Seward, and St. Mary's Hospital challenge the application of the rural Nebraska hospital hospital inpatient per diem cost limitation to their claims of costs reimbursable under Medicare in their fiscal years ending in 1980, 1981, 1982, and 1983. Plaintiffs Good Samaritan Hospital and Mary Lanning Memorial Hospital challenge the application of the rural Nebraska per diem

cost limits to their claims of costs reimbursable under Medicare in their fiscal years ending in 1981, 1982 and 1983. Plaintiff Memorial Hospital of Dodge County challenges the application of the rural Nebraska hospital inpatient per diem cost limitation to its claim of costs reimbursable order [sic] Medicare in its fiscal years ending in 1980, 1981, 1982, 1983 and 1984.

31. During the cost years under appeal, the State of Nebraska had one of the nation's highest use of part-time employees in the field of hospital services. The rural Nebraska wage index in the Medicare hospital cost limits schedules during this period was one of the lowest in the nation.

32. The plaintiffs in this case had high levels of part-time employee use during the years under appeal.

33. A study performed by a consultant for the plaintiffs demonstrated that an adjustment factor of 1.1104 (i.e. 11.04%) applied to the rural Nebraska wage index would correct for the adverse effect of the failure of the BLS wage index to account for part-time employees. Significantly, when HCFA developed its own wage index from 1982 hospital data which accounted for the use of part-time employees (see paragraph 17, above), the wage index for rural Nebraska increased by an almost identical 11.25%, from .7411 to .8244.

34. None of the plaintiffs is located in a geographical area which had been designated by OMB as an SMSA during the cost years under appeal. Memorial Hospital of Dodge County is located 6 miles from the Omaha, Nebraska SMSA; Memorial Community Hospital is located 25 miles from the Omaha SMSA; Memorial Hospital, Seward is located 30 miles from the Lincoln, Nebraska SMSA; St. Mary's Hospital is located 50 miles from the Omaha and the Lincoln SMSAs. Good Samaritan is located 124 miles from the Lincoln SMSA;

Mary Lanning Memorial Hospital is located 100 miles from the Lincoln SMSA and 160 miles from the Omaha SMSA.

35. Each of the plaintiffs incurred costs comparable to those of SMSA-located Nebraska hospitals in the period 1979-1983. The four plaintiffs located within 50 miles of an SMSA directly competed with SMSA hospitals to attract staff. Good Samaritan and Mary Lanning Memorial Hospitals had to offer SMSA-level wages to attract staff out to their remote locations.

36. Plaintiff Memorial Community Hospital is located in a county which OMB has determined to be within the Omaha Metropolitan Statistical Area (MSA), based upon the standards for designating MSAs published by OMB in 1980 and upon 1980 census data. OMB announced this determination in January 1983. Memorial Community Hospital requested from HCFA and was refused a retroactive reclassification under 42 C.F.R. § 405.460 to the Omaha urban cost limits per diem level, beginning with its 1980 cost year and covering its 1981, 1982 and 1983 cost years. HCFA and the Secretary have asserted that the Department cannot grant any retroactive reclassification in the Medicare cost limits program because, *inter alia*, the Department has no control over OMB's actions.

37. Rural Nebraska hospitals experienced severe shortages of nursing personnel in their 1978-1980 cost year periods which resulted in reduced wage costs reported on Medicare cost reports.

38. Rural Nebraska wage data from cost reporting periods of 1978-1980 were not equitably or validly adjusted for use in the Medicare hospital cost limits in 1980-82.

39. Each plaintiff was supplied by Blue Cross of Nebraska with a Medicare hospital inpatient rural Nebraska per diem cost limit figure for each fiscal year

under appeal as calculated by Blue Cross/Nebraska according to the Medicare cost limits regulation and cost limits schedule.

40. Each plaintiff either used the per diem cost limit figure supplied by Blue Cross/Nebraska to effect a downward adjustment of this plaintiff's claimed Medicare costs for reimbursement on the cost reports for fiscal years 1980-83, or else Blue Cross/Nebraska inserted the figure in the cost report as audited. HCFA has refused to reimburse the plaintiffs for their reasonable costs in excess of the cost limits.

41. Plaintiff Memorial Hospital of Dodge County significantly altered its accounting methodology beginning with its 1980 fiscal year cost report, in consultation with Blue Cross/Nebraska, to respond to the adverse financial impact of the routine cost limits per diem figure which Blue Cross/Nebraska intended to insert in that plaintiff's 1980 cost report. After this alteration there was still an adverse impact on the cash flow of the hospital.

42. None of the plaintiffs incurred excessive costs or provided luxurious services in offering necessary health services to Medicare beneficiaries during the cost years under appeal. Neither the fiscal intermediary nor the defendant was or is in possession of any studies or evaluations of the plaintiffs showing that any of the plaintiffs either provided necessary health services to Medicare beneficiaries at excessive cost, or provided luxurious services.

43. For each cost year of each plaintiff, the effect of the application of the rural Nebraska per diem cost limitation was to severely and improperly reduce the amount of Medicare reimbursement to less than the statutory standard of reasonable cost properly owed the hospital under the statute. 42 U.S.C. § 1395x(v) (1) (A). The plaintiffs have necessarily had to recoup lost reimbursement

through shifting costs to non-Medicare patients in subsequent cost years.

44. The plaintiffs filed appeals for each of their affected cost years at the Provider Reimbursement Review Board (PRRB or Board). The appeals challenged the validity of the Secretary's cost limits methodology. In particular, the plaintiffs challenged the use of a wage limit methodology which failed to distinguish between full and part-time employees; the use of the SMSA designation as the sole means by which a hospital is classified as an urban hospital without possibility of exception; the use of stale BLS data to construct the wage index applied to any given year, and the conclusive use of the cost limits. In addition, plaintiff Memorial Community Hospital challenged HCFA's refusal to reclassify it as an urban hospital effective with its FY 1980 cost year, when OMB officially designated Memorial Community Hospital's county as part of the Omaha SMSA based on 1980 census data.

45. On June 21, 1988 the plaintiffs filed requests for expedited judicial review with the PRRB, pursuant to 42 U.S.C. § 1395oo(f) (1). The plaintiffs sought a determination by the PRRB that it could not decide the issues under appeal because the PRRB is bound by the Secretary's regulations (including the cost limits schedules) and therefore could not grant the relief the plaintiffs sought.

46. On August 11, 1988 the PRRB granted expedited judicial review for the following plaintiffs and cost years:

Good Samaritan Hospital	FYE 1981, 1982, 1983
Mary Lanning Memorial Hospital	FYE 1980, 1981, 1982, 1983
Memorial Community Hospital	FYE 1980, 1981, 1982, 1983
Memorial Hospital of Dodge County	FYE 1981, 1982, 1983, 1984
Memorial Hospital (Seward)	FYE 1980, 1982, 1983
St. Mary's Hospital	FYE 1980, 1982, 1983

The PRRB letters granting expedited judicial review are attached as Exhibit A.

47. On August 11, 1988 the PRRB issued decisions stating it did not have jurisdiction over the following appeals:

Memorial Hospital Dodge County	FYE 1980
Memorial Hospital (Seward)	FYE 1981
St. Mary's Hospital	FYE 1981

See Exhibit B. The Board found that the hearing requests on the routine cost limits issue for these years were not filed within 180 days after the issuance of the NPR. However, each of these plaintiffs had timely filed a hearing request for the cost year under appeal on another issue. The Medicare regulation at 42 C.F.R. § 405.1841(a) (1) permits a provider, once it has timely filed an appeal for a given cost year, to later add additional issues.

48. Plaintiffs file this complaint within 60 days of the date of the final decisions of the PRRB. This appeal is therefore timely filed.

COUNT I

49. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 48 as if fully set forth herein.

50. The Secretary's promulgation of the costs limits regulation and cost limits schedules was arbitrary, capricious and an abuse of discretion and otherwise not in accordance with law within the meaning of the Administrative Procedure Act, 5 U.S.C. §§ 553 and 706, because of, but not limited to, the following reasons:

(a) the use of a wage index calculated without regard to the effect of the use of part-time or full-time employee data is irrational, inequitable and fails to consider an important aspect of the cost limits system which is the need to use comparable data to prepare estimates;

(b) the principle that hospitals should be classified as rural or urban without possibility of an exception has no rational basis;

(c) the reliance upon data which is known to be outdated is irrational;

(d) the Secretary was on notice from comments filed with HHS, and from data and information provided to or developed within HHS, that the regulation and cost limits schedules were erroneous and unfair. Failure to alter the regulation or schedules was arbitrary, capricious and an abuse of discretion,

(e) the Secretary's decision in setting cost limits was based on inadequate evidence;

(f) the Secretary relied upon factors which Congress did not intend for him to consider.

COUNT II

51. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 50 as if fully set forth herein.

52. The cost limits regulation and hospital cost limits schedules violate the Medicare statute, and specifically 42 U.S.C. § 1395x(v) (1) (A), and therefore are not in accordance with law, because of, but not limited to, the following reasons:

(a) they deny reimbursement for actual costs necessarily incurred in the efficient delivery of health services to Medicare beneficiaries;

(b) they establish estimates of costs which have an inadequate basis in fact, a process which runs contrary to the statutory requirement that the Medicare program reimburse the actual costs of providers;

(c) they establish stringent criteria, not authorized under the statute, concerning geographical locations as an unvarying basis for reimbursing providers;

(d) the regulation does not provide for suitable retroactive corrective adjustments to the cost limits when the costs limits methodology can be shown to rely upon inappropriate and inaccurate wage, geographic, or cost report data;

(e) they cause providers to shift the costs of the care of Medicare patients on to non-Medicare payors;

(f) they are applied on a conclusive rather than a presumptive basis.

COUNT III

53. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 52 as if fully set forth herein.

54. The refusal of the defendant to reclassify Memorial Community Hospital as located within the Omaha SMSA beginning with its 1980 cost year is arbitrary, capricious, an abuse of decision and contrary to law.

55. The defendant's refusal to reclassify Memorial Community Hospital as located within the Omaha urban area is an abrogation of its own responsibility for administering the Medicare Program and an unlawful delegation of authority to OMB.

COUNT IV

56. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 55 as if fully set forth herein.

57. The PRRB's decision that it does not have jurisdiction over the appeals of Memorial Hospital of Dodge County (FYE 1980), Memorial Hospital (Seward) (FYE 1980), and St. Mary's Hospital (FYE 1981) with respect to the routine cost limits issue is arbitrary, capricious, an abuse of discretion and contrary to law

because of, but not limited to, the following reasons:

(a) These plaintiffs filed timely hearing requests on other issues for the cost years under appeal;

(b) The regulation at 42 C.F.R. § 405.1841(a) permits providers to add additional issues to an appeal of a given cost year once a hearing request for a cost year has been timely filed.

COUNT V

58. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 57 as if fully set forth herein.

59. Under the Medicare prospective payment system (PPS), for cost reporting periods beginning on or after October 1, 1983, hospitals are paid a predetermined amount per Medicare discharge, depending upon the diagnosis-related group (DRG) into which the patient is classified. 42 U.S.C. § 1395ww(d). For the first four PPS years, a hospital's PPS payment has two components: a hospital-specific portion (termed in the statute the "target" amount) and a federal portion (termed in the statute the "DRG" rate). In the first PPS year, the ratio is 75% hospital-specific/25% federal; in the second year the ratio is 50%/50%; in the third year the ratio is 45%/55%; and in the fourth PPS year, the ratio is 25%/75%. Following the four transition years, hospitals are paid 100% the federal rate. 42 U.S.C. § 1395ww(d) (1) (C).

60. The hospital-specific portion is based upon a hospital's allowable Medicare operating costs in a "base year", i.e., the hospital's cost reporting period ending on or after September 30, 1982. 42 U.S.C. § 1395ww(d) (1) (A) (i) (I), incorporating § 1395ww(b) (3) (A). Each of the plaintiffs has its PPS base year as one of the years under appeal in this case.

61. The Medicare statute defines the "target amount"

as "the allowable operating costs of inpatient hospital services" in the base year. 42 U.S.C. § 1395ww(d) (1) (A) (i) (I), incorporating subsection (b) (3) (A). If a hospital's allowable operating costs for the base year are increased for any reason, including as a result of a base year appeal, the hospital-specific rate for all PPS years should therefore be adjusted to reflect the additional allowable base year costs. Thus, if this court rules in plaintiffs' favor on Counts I, II and III of this Complaint, the hospital-specific rates for all of the plaintiffs' PPS years should be automatically adjusted to reflect the increase in allowable base year costs.

62. The Secretary's regulations prohibit automatic retroactive adjustments to hospital-specific rates, to reflect additional allowable base year costs. 42 C.F.R. § 412.72(a) (3)(ii). Instead, the Secretary's regulations provide that the hospital-specific rate will be retroactively adjusted only if the intermediary failed to use the "best data available" at the time it calculated the hospital-specific rate, and if "the estimation [of base year costs] was unreasonable and clearly erroneous in light of the data available at the time the estimation was made." 42 C.F.R. § 412.72(b) (2). The regulations further exclude from administrative and judicial review "any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation." 42 C.F.R. § 412.72(b) (3). These regulations are contrary to the statute which requires that *all* allowable base year costs be reflected in the hospital-specific rates for all PPS years.

63. The Secretary has already indicated he will not make a retroactive adjustment to the hospital-specific rates to include additional base year costs recognized as a result of the invalidation of a Medicare regulation or policy. *See e.g.*, 53 Fed. Reg. 22031 (June 13, 1988) ("If a [base year] disallowance was based on a legal interpreta-

tion later held incorrect by the courts, the validity of the [hospital-specific] rates would not be affected if the intermediary made a good faith attempt to act in accordance with the law and regulations as they were understood when the rates were established.") Thus, the result under the Secretary's regulations is that the hospital-specific rates for PPS years will continue to be calculated under an invalidated regulation or policy. This result is (1) contrary to the Medicare statute which requires that the hospital-specific rate be based on all allowable base year operating costs; and (2) inconsistent with the regulation at 42 C.F.R. § 412.72(a) (3) (ii) which requires an automatic adjustment to the hospital-specific rate of PPS years beginning after the date a hospital wins its base year appeal. Hence this result is contrary to law.

WHEREFORE, the plaintiffs pray judgment against the defendant as follows:

1. For a declaration that the action of the Secretary in promulgating and applying the cost limits regulation and the hospital cost limits schedules was arbitrary, capricious, an abuse of discretion and not in accordance with law as to:

A. the use of a wage index based on data which does not take into account the degree and effect of part-time employee use;

B. the unvarying classification of providers as urban or rural based upon OMB definitions;

C. the use of stale data inadequately updated as the basis for a cost limitation of a hospital's actual costs in subsequent cost years;

D. the conclusive use of the cost limits to deny reimbursement of reasonable costs.

2. For an order declaring that the cost limits schedules effective from June 1, 1979 through September 30, 1983 were illegal on their face and/or as applied in this case.

3. For an order requiring the Secretary to apply a wage index which takes into account the high use of part-time employees by hospitals in Nebraska to the cost years under appeal.

4. For an order requiring the Secretary to reimburse plaintiff hospitals according to the urban cost limits applicable to the nearest SMSA for the cost years under appeal.

5. For an order requiring the Secretary to reimburse plaintiff hospitals for their reasonable costs for the years under appeal without regard to the cost limits.

6. For a declaration that the Secretary's failure to reclassify Memorial Community Hospital as within the Omaha urban area as of 1980 is arbitrary, capricious and not in accordance with law, and for an order that the plaintiff shall be so reclassified and shall be reimbursed according to the cost limits applicable to the Omaha SMSA for the cost years under appeal.

7. For a declaration that the PRRB has jurisdiction over the appeals of Memorial Hospital of Dodge County (FY 1980), Memorial Hospital (Seward) (FY 1981), and St. Mary's Hospital (FY 1981).

8. For an order of this court directing the Secretary to adjust plaintiffs' hospital-specific rates for all PPS transition years to reflect additional allowable base year costs recognized as a result of this appeal, and to make payment accordingly, with interest.

9. For an order awarding plaintiffs their costs and interest in accordance with 42 U.S.C. §§ 1395oo(f) 1395x(v) (1) (B), at the rate of one times the rate of interest payable on obligations of the Federal Hospital Insurance Trust Fund in effect at the time this civil action was filed, for this action.

10. For such other relief as this Court deems just and appropriate.

Respectfully submitted,

/s/ Charles Thone
Charles Thone

/s/ Douglas L. Curry
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(Certificate of Service omitted in printing.)

[Exhibit A reprinted in Pet. App. 37a-54a]

(Exhibit B omitted in printing.)

UNITED STATES DISTRICT COURT
DISTRICT OF NEBRASKA

Civil Action No. 88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

ANSWER TO AMENDED COMPLAINT

Defendant, Otis R. Bowen, M.D., Secretary of Health and Human Services, answers the Amended Complaint as follows:

FIRST DEFENSE

Plaintiffs have failed to state a claim upon which relief can be granted.

SECOND DEFENSE

This Court lacks jurisdiction over (1) the claim by Memorial Hospital (Seward) for its fiscal year ending September 30, 1981, (2) the claim by Memorial Hospital of Dodge County for its fiscal year ending December 31, 1980, and (3) the claim by St. Mary's Hospital for its fiscal year ending September 30, 1981.

THIRD DEFENSE

Defendant answers the numbered paragraphs of the Amended Complaint as follows:

1. Admits.
2. Admits.
3. Denies, except to aver that this action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*
4. Admits, except to deny that this Court has jurisdiction over (1) the claim by Memorial Hospital (Seward) for its fiscal year ending September 30, 1980, (2) the claim by Memorial Hospital of Dodge City for its fiscal year ending December 31, 1980, and (3) the claim by St. Mary's Hospital for its fiscal year ending September 30, 1981.
5. Admits.
6. Admits.

7-9. Paragraphs 7, 8 and 9 purport to quote and characterize the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, as such these paragraphs constitute conclusions of law and not allegations of fact to which an answer is required. Insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately quote the Act. Defendant respectfully refers the court to the cited provisions of the Social Security Act, 42 U.S.C. §§ 1395cc, 1395f(b)(1)(A), 1395x(v)(1)(A), and the cited House and Senate Reports for an accurate and complete statement of their contents.

10. Admits.
11. Admits.
12. Admits.
13. The first sentence of paragraph 13 sets forth plaintiffs' characterization of wage indices and data utilized by the Health Care Financing Administration ("HCFA") to which no answer is required. Insofar as an answer may be deemed to be required, defendant denies the allegations in the first sentence, except to admit that the data was not adjusted for part-time employee status. Defendant admits the allegations in the last sentence but avers that the data

used to compute the BLS wage index was the best data available at the time.

14. Defendant admits the wage index for states with a high part-time employee use may have been low because the wage index was not adjusted for full time employee equivalency.
15. Denies.
16. Admits.
17. Admits.
18. Admits.
19. Denies.
20. Defendant denies the allegations in the first sentence, and defendant respectfully refers the court to the regulations, particularly 42 C.F.R. 405.460, for an accurate and complete statement of the applicable cost limit exceptions. Defendant admits that Memorial Community Hospital was denied its request for reclassification by HCFA, but defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations as to the other hospitals.
21. Paragraph 21 contains conclusions of law and not allegations of facts to which an answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in paragraph 21.
22. Defendant admits that the data used to create the labor and non-labor components for the per diem rates or wage index listing was based on costs for previous years, but defendant avers that the data was the most recent data available.
23. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in this paragraph. Defendant, however, refers the court to 42 C.F.R. § 405.460 for an accurate and complete statement of the exceptions available to providers.

24. Paragraph 24 contains conclusions of law and not allegations of fact to which an answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations.

25. Defendant admits the allegations in the first three sentences and the last two sentences. Defendant denies the allegations in the fourth sentence, but avers that the intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit, if an audit is performed.

26. Admits.

27. Admits.

28. Admits.

29. Denies.

30. Admits.

31. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence. Defendant admits the allegations in the last sentence.

32. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 32.

33. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence of paragraph 33. The second sentence sets forth plaintiffs' characterization of the HCFA wage indices to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the wage indices. Defendant refers the court to the revised wage index for an accurate and complete statement of its terms.

34. Admits.

35. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 35.

36. Defendants admits the allegations in the first two sentences. The last sentence sets forth plaintiffs' characterization of HCFA's decision on Memorial Community Hospital's request for retroactive reclassification to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the decision. Defendant refers the court to the Department's decision for an accurate and complete statement of its reasons.

37. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 37.

38. Paragraph 38 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 38.

39. Admits.

40. Defendant admits the allegations in the first sentence of paragraph 40. The second sentence contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies.

41. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 41.

42. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence of paragraph 42. Defendant admits the allegations in the second sentence of paragraph 42.

43. The first sentence of paragraph 42 [sic] contains conclusions of law to which no answer is required, but insofar an answer may be deemed to be required defendant denies the allegations. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the second sentence.

44. Admits.

45. Admits.

46. Admits, except to deny that the Provider Reimbursement Review Board granted expedited review to Mary Lanning Memorial Hospital for its fiscal year 1980.

47. Defendant admits the allegations in the first two sentences. The last two sentences contain plaintiffs' conclusions of law to which no response is required; insofar as an answer may be deemed to be required, defendant denies.

48. Admits.

49. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 48.

50. Paragraph 50 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 50.

51. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 50.

52. Paragraph 52 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 52.

53. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 52.

54-55. Paragraphs 54 and 55 contain plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be required, defendant denies paragraphs 54 and 55.

56. Defendant reiterates and incorporates his answers to paragraphs 1 through 55.

57. Paragraph 57 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 57.

58. Defendant reiterates and incorporates his answers to paragraphs 1 through 57.

59. Paragraph 59 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this paragraph constitutes conclusions of law and not allegations of fact to which an answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. §§ 1395ww(d) for an accurate and complete statement of its terms.

60. The first sentence of paragraph 60 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this sentence constitutes conclusions of law and not allegations of fact to which an response is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. §§ 1395ww(d)(1)(A)(i)(I) and 1395ww(b)(3)(A) for an accurate and complete statement of their terms. Defendant admits allegations in the last sentence.

61. The first sentence of paragraph 61 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this sentence constitutes conclusions of law and not allegations of fact to which an answer is required; insofar as an answer may be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. § 1395(d)(1)(A)(i)(I) for an accurate and complete statement of its terms. The last sentence of paragraph 61 contains conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations.

62. The first three sentences of paragraph 62 set forth plaintiffs' characterizations of certain regulations to which no answer is required; insofar as answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the regulations. Defendant respectfully refers the Court to 42 C.F.R. §§ 412.72(a)(3)(ii), 412.72(b)(2), and 412.72(b)(3) for an accurate and complete statement of their terms. The last sentence in paragraph 62 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in this sentence.

63. The first sentence in paragraph 63 sets forth plaintiffs' characterization of a Federal Register Notice issued by the defendant to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the notice. Defendant respectfully refers the court to the notice for an accurate and complete statement of its terms. The remaining sentences in paragraph 63 contain plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in these sentences.

Defendant hereby specifically denies all of the allegations of the complaint not hereinbefore otherwise answered.

WHEREFORE, defendant request that this Amended Complaint be dismissed and the defendant awarded costs and be granted such other relief to which it may be entitled.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF
HEALTH AND HUMAN SERVICES, DEFENDANT.

[FILED FEB. 16, 1990]

JUDGMENT

In accordance with today's memorandum on the plaintiff's and defendant's cross-motions for summary judgment,

IT IS ORDERED that:

1. judgment is entered for the plaintiffs on the issue of corrective adjustments to cost limit rules;
2. judgment is entered for the defendant on all other issues.

The case is remanded to the Secretary for a hearing from which he (1) shall apply to the cost years under appeal a wage index that takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-SMSA designation of the plaintiffs in determining whether the aggregate reimbursement pro-

duced by the methods of determining costs has proved to be adequate.

Dated February 16, 1990.

BY THE COURT
/s/ [SIGNATURE ILLEGIBLE]
United States District Judge

Supreme Court, U.S.
FILED
NOV 25 1992
OFFICE OF THE CLERK

No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED FOR REVIEW

Under the Medicare statute for the years under appeal, hospitals were to be reimbursed for their "reasonable cost" of providing services to Medicare patients. The question presented for review is whether clause (ii) of 42 U.S.C. § 1395x(v)(1)(A), which provides for "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," requires substantive adjustments to any individual provider's reimbursement when the regulatory methods for determining reasonable cost (including the cost limits and their exceptions) result in inadequate or excessive reimbursement for that provider.

LIST OF PARTIES

The petitioners are Good Samaritan Hospital, The Mary Lanning Memorial Hospital Association, Memorial Community Hospital, Inc., Memorial Hospital Of Dodge County, Memorial Hospital and St. Mary's Hospital.

The respondent is Louis W. Sullivan, M.D., Secretary of Health and Human Services.

RULE 29.1 LIST

The parent company of Good Samaritan Hospital is Good Samaritan Health Systems, Inc. The parent company of Memorial Community Hospital, Inc. is Memorial Community Health System, Inc. The parent company of St. Mary's Hospital is St. Elizabeth Health System.

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In the Supreme Court of the United States

October Term, 1992

No. 91-2079

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals is reported at 952 F.2d 1017 and is reprinted at Pet. App. 1a. The memorandum decision of the district court is reported at [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,400 (D. Neb. Feb. 16, 1990), and is reprinted at Pet. App. 19a.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. Pet. App. 1a. A timely petition for rehearing was denied on February 7, 1992. Pet. App. 18a. On April 28, 1992, Justice Blackmun granted an extension of time to file the petition for certiorari until July 6, 1992. The petition was filed on June 26, 1992, and was granted on October 13,

1992. The jurisdiction of this Court rests upon 28 U.S.C. § 1254(l) (1992).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1395x(v) Reasonable costs

(1) (A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method

reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

STATEMENT OF THE CASE

Medicare Statutory And Regulatory Framework

For the cost reporting periods under appeal in this case (fiscal years 1980-1983), the Medicare statute required the Secretary of Health and Human Services to reimburse providers the lower of the "reasonable costs" of furnishing covered services to Medicare beneficiaries or the customary charge for such services. 42 U.S.C. § 1395f(b) (1992). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services...." 42 U.S.C. § 1395x(v)(1)(A)(1992).[1]

---

[1]For cost years beginning on or after October 1, 1983, most hospitals became subject to the Medicare prospective payment system (PPS), under which hospitals are paid a predetermined amount for each discharge, depending on the diagnosis of the patient. 42 U.S.C. § 1395ww(d) (1992). The first four years of PPS were transition years, during which

The Medicare statute directs the Secretary to establish a method or methods for calculating "reasonable costs." *Id.* However, the statute also requires the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining reasonable costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) (hereinafter "clause (ii)"). This requirement was in the original Medicare statute enacted in 1965. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 311 (1965).

One of the methods by which the Secretary determines reasonable cost is the application of "cost limits." The authority to establish these limits was contained in section 223 of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329. The Senate Committee explained that the cost limits were designed to prevent the reimbursement of costs attributable to inefficiency or the provision of luxury services, and were to be applied on a presumptive basis. S. Rep. No. 1230, 92d Cong., 2d Sess. 187, 188 (1972). The Committee further indicated that providers "would of course have the right to obtain reconsideration of their classification for purposes of the cost limits" and "to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 189.

Pursuant to this statutory authority, in 1974 the Secretary first promulgated regulations establishing limits on hospital costs and certain exceptions thereto. 42 C.F.R. § 405.460.[2]

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a portion of a provider's payment was based upon its "reasonable cost" in its base year (generally FY 1982).

[2] The regulations were originally codified at 20 C.F.R. § 405.460 (1974) and are now codified at 42 C.F.R. § 413.30 (1991). Because the case law and the administrative record herein refer to 42 C.F.R. § 405.460, that designation is used throughout the brief.

See 39 Fed. Reg. 20164 (1974). Since that time schedules of hospital routine cost limits have been published annually.

The Secretary's cost limit regulations for the years at issue here classified hospitals as either urban (*i.e.*, located in a Standard Metropolitan Statistical Area ("SMSA")) or rural (*i.e.*, not in a SMSA). Beginning with cost reporting periods starting on or after July 1, 1979, the cost limit regulations also used a "wage index" based on geographic location to determine the labor-related component of a provider's costs. Rural areas generally have a lower wage index than urban areas. The data used to develop the wage index, drawn from the Bureau of Labor Statistics ("BLS"), did not distinguish between part-time and full-time employees. As a result, the wage index was distorted downward for those areas that had a high proportion of part-time employees.[3] This distortion was known by the Secretary from the earliest use of the wage index.[4]

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[3] BLS received data on the total hospital wages paid during the quarter, and the total number of hospital employees working during the month. From these data, BLS computed an "average monthly hospital wage" for each SMSA or each non-SMSA county. However, the "number of employees" counted all personnel, including part-time employees, equally. (A.R. 184).

The effect of this failure to distinguish part-time from full-time employees is best illustrated by a simple example. Assume that a county has one hospital which has total monthly wages of $100,000 and employed 100 full-time employees. BLS would calculate the average monthly hospital wage for the county as $1000 per month. However, if the hospital with the same $100,000 payroll employed 200 part-time employees, BLS would calculate the average monthly hospital wage for the county to be only $500 per month. As HCFA stated in an internal memorandum dated July 1, 1881, the effect of counting part-time workers the same as full-time workers is that "the wage index will be distorted to the extent various areas employ different proportions of part-time workers. The result can be the application of a lower cost limit to some hospitals then [sic] is warranted by real differences in wage levels." (Plaintiffs' Motion For Summary Judgment, Exhibit D.)

[4] *See* Exhibits A, C, D, and G to Plaintiffs' Motion for Summary Judgment; Rulemaking Record (R.R.) filed by the Secretary at 1237, 1238, 1393, 1469, 1072, 1393.

One part of the cost limits regulations for determining reasonable costs permits selected providers who fall within certain narrow categories to request a reclassification, exemption or exception from the limits. 42 C.F.R. § 405.460(d), (e) and (f). As the parties agree, Pet. App. 4a, n.4, none of these provisions permit relief from the cost limits based on a showing that the cost limits fail to account for reasonable necessary expenditures on behalf of Medicare beneficiaries. In particular, as relevant here, the regulations make no allowance for a provider to show that the use of many part-time employees is reasonable or for a rural hospital to show that it has to offer wages comparable to a nearby urban hospital to compete for employees in times of shortages. Thus, under the regulations as the Secretary applies them, unless a provider's claim for relief qualifies as one of the narrow exemptions or exceptions set forth in the regulation, no relief is available in the form of a retroactive corrective adjustment when the reimbursement proves to be inadequate to cover a provider's reasonable costs.

This Litigation

Each of the petitioners is classified as a rural Nebraska hospital for Medicare purposes. Hospitals in rural Nebraska as a whole, including petitioners, employ a percentage of part-time employees that is significantly higher than the national average. A.R. 129, 132.[5] Due to a nursing shortage, these rural hospitals also offered wages comparable to urban hospitals in an effort to attract needed staff.[6]

Prior to the cost years at issue, when the cost limits did not use a wage index, each of the petitioners' costs were below the

[5]"A.R." denotes the Administrative Record filed by the Secretary. The percentages of part-time employees used by the individual petitioners are found at A.R. 126, 420, 531, 690, 823, 925.

[6]A.R. 126, 420, 531, 690, 822, 925.

cost limits. When the methodology was changed to incorporate the wage index, each of the petitioners exceeded the rural Nebraska Medicare cost limits for the first time, although nothing had changed in their method of providing services. This occurred primarily because the wage index component of the cost limits did not account for the use of part-time employees. There is no evidence in the record, or suggestion by the Secretary, indicating that the petitioners' costs were unnecessary, or were incurred as a result of inefficiency or the provision of luxurious services, or that the use of part-time employees was inefficient. A.R. 292. To the contrary, in rural areas the use of part-time employees promotes efficiency and helps to hold down costs.

Pursuant to 42 U.S.C. § 1395oo (1992), each of the petitioners filed an appeal to the Provider Reimbursement Review Board ("PRRB") for the years in which they exceeded the cost limits (FYEs 1980-1983). The hospitals contended in their appeals that their costs in excess of the cost limits were nonetheless reasonable. They challenged the validity of the Medicare cost limits, claiming that they (1) did not account for the use of part-time employees and (2) did not permit rural hospitals to show that their circumstances required them to incur wage costs similar to those of urban hospitals. In addition, the hospitals claimed that the cost limits were applied in a conclusive rather than a presumptive fashion, because there was no regulatory mechanism by which the providers could obtain relief from the limits for these unavoidable expenses. They also claimed that, even if the cost limits were found to be valid as across-the-board regulations, the petitioners were entitled to individual retroactive corrective adjustment to their aggregate reimbursement under clause (ii) because their costs over the limits were reasonable.[7] A.R. 38, 372, 465, 605, 733, 878.

[7]In addition, petitioner Memorial Community Hospital challenged the Secretary's denial of its request for reclassification from "rural" hospital

The Board took jurisdiction over the appeals of the six hospitals, for a total of twenty cost years.[8] Pet. App. 37a-45a. Because the Board could not invalidate the Secretary's cost limits regulations, 42 C.F.R. § 405.1867 (1991), and did not believe it could award reimbursement in excess of the cost limits, the Board determined that it did not have the authority to grant the hospitals the relief they sought; *i.e.*, reimbursement over the cost limits. The Board therefore granted the hospitals' requests for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) (1992), thereby allowing the hospitals to take their challenge directly into district court. *Id.*

On cross-motions for summary judgment, the district court agreed with the hospitals that the statute required the cost limits to be applied only on a presumptive rather than a conclusive basis. Pet. App. 26a. The court held that clause (ii) required the Secretary to make a retroactive adjustment to the providers' reimbursement where the Secretary's cost limits method, even though valid, resulted in inadequate reimbursement of the providers' individual aggregate reasonable costs. In so holding, the court relied on the prior decision of the Eighth Circuit in *St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (8th Cir. 1987).[9] Pet. App. 29a.

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status to "urban" hospital status. Both the district court and the court of appeals ruled against Memorial Community Hospital on this issue, and it is not now before the Court.

[8]The Board denied jurisdiction over three cost years on the ground that the appeals for those years were not timely filed. That issue is not before the Court.

[9]Other courts of appeals similarly have held that under clause (ii) the Secretary is required to make a retroactive adjustment when a provider receives reimbursement that is lesser or greater than its actual, reasonable cost, as calculated under the cost limits and any other method for determining reasonable cost. *See Medical Center Hospital v. Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Springdale Convalescent*

The district court rejected the Secretary's contention that *St. Paul-Ramsey* was no longer good law after this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988) (hereinafter "*Georgetown*"). Pet. App. 31a. The Secretary argued that *Georgetown* meant that clause (ii) only required year-end book-balancing to reconcile a provider's interim payments received during the year with the amount due a provider at the end of the year under the regulations. The district court disagreed, holding that *Georgetown* established only that clause (ii) does not authorize retroactive *rulemaking* and did not alter *St. Paul-Ramsey's* conclusions that clause (ii) does require *case-by-case adjustments* for individual providers of the kind the hospitals seek, where the regulatory methods, though valid, result in inadequate reimbursement. *Id.* The district court accordingly remanded the case to the Secretary "for a hearing from which he (1) shall apply to the cost years under appeal a wage index which takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-MSA designation of the [hospitals] in determining whether the aggregate reimbursement produced by the methods of determining costs has proved to be inadequate." J. A. 30.

The court of appeals reversed, holding that the hospitals were not entitled to a suitable retroactive corrective adjustment where the cost limits regulation resulted in inadequate reimbursement. The court concluded that its prior interpretation of clause (ii) in *St. Paul-Ramsey* had been overruled by the Supreme Court's decision in *Georgetown*. Pet. App. 11a.

Center v. Mathews, 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973). Prior to 1988, only one court had held that clause (ii) is limited to year-end book-balancing. *Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250 (3d Cir. 1978).

It read *Georgetown* as holding that the retroactive corrective adjustment required by clause (ii) is limited to year-end "book-balancing" to reconcile the monthly interim estimated payments a provider receives during the year with the amounts actually due for the year pursuant to the Secretary's methods of determining reasonable cost. Pet. App. 12a. It therefore concluded that the kind of retroactive corrective adjustment sought by the plaintiffs, which would reimburse costs over the cost limits, would amount to retroactive rulemaking that *Georgetown* prohibited.[10] Pet. App. 13a. In short, the court held that the petitioners were not entitled to a determination of whether their reimbursement was reasonable.[11]

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[10]The D.C. Circuit in *Hennepin County v. Sullivan*, 883 F.2d 85 (D.C. Cir. 1989), *cert. denied*, 493 U.S. 1043 (1990), also interpreted *Georgetown*'s observation regarding the Secretary's past position as a holding that clause (ii) only permits the Secretary to perform year-end book-balancing. In contrast, the Ninth Circuit expressly rejected this interpretation of *Georgetown* in *Mt. Diablo Hospital v. Sullivan*, 963 F.2d 1175 (9th Cir. 1992), *pet. for cert. filed*, 61 U.S.L.W. 3356 (U.S. October 22, 1992) (No. 92-720) (Pet. App. 54a), a case which also involves a challenge to the cost limits for failure to account for part-time employees. Instead, the Ninth Circuit held that *Georgetown* did not overrule its earlier decision in *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985), which interpreted clause (ii) to require the Secretary to make a retroactive adjustment to reimburse a provider for all its "reasonable costs," even if those costs exceeded the cost limits and do not qualify for treatment as an exception or exemption under the Secretary's regulations.

[11]The court of appeals further held that the Secretary's cost limit methodology was valid and reasonable. Pet. App. 14a. Although the BLS data used for the wage index did not account for the difference between full-time and part-time employees, the court deferred to the Secretary's conclusion that they were the best data then available. Petitioners do not challenge that holding before the Court. However, the conclusive application of the cost limits to prevent reimbursement of reasonable costs which exceed the limits is intertwined with the petitioners' arguments on clause (ii) and is therefore before the Court.

SUMMARY OF ARGUMENT

The plain language of clause (ii), this Court's reading of clause (ii) in *Georgetown* and the legislative history of the cost limit regulations argue for providing petitioners the relief they seek.

The petitioners contend that the plain meaning of clause (ii) requires retroactive adjustments to individual providers when the Secretary's cost determination methods result in reimbursement of less than reasonable costs. In *Georgetown*, this Court expressly and repeatedly confirmed that clause (ii) requires substantive adjustments to the reimbursement of individual providers when the Secretary's methods produce inadequate reimbursement. The command of clause (ii) is not met simply by calculating the amounts due pursuant to the methods.

The legislative history of the 1972 Amendments to the Social Security Act which established the cost limits shows that Congress recognized that across-the-board cost limits could only be employed if individual providers had an opportunity to seek relief. The congressional committees debating the cost limits approach recognized the value of general cost limitations in streamlining the cost determination process. At the same time, however, the committees made clear their intent that any provider—not just some—should be permitted to prove costs in excess of the limits were necessary and justified. Never in the debate on this issue did Congress abandon the principle of reasonable cost reimbursement for *all* providers.

Only through "interpretative gymnastics" does the Secretary arrive at his position that clause (ii) means procedural year-end book-balancing, and that relief from the cost limits is available only to the relatively few providers who meet the Secretary's narrow regulatory exceptions. Such a construction violates all accepted standards of statutory construction.

An adjudication by the PRRB of the adequacy of an individual hospital's reimbursement as called for by clause (ii) would not

involve the Secretary in retroactive rulemaking. Clause (ii) does not authorize the making of new rules to govern past conduct. Nor do the petitioners seek any such new rules. Instead, they seek only the individualized adjudication necessary to obtain adequate reimbursement of reasonable costs, a process this Court in *Georgetown* clearly distinguished from rulemaking.

No deference should be accorded the Secretary's interpretation of clause (ii) or his position that relief under the cost limits should be available only to the few falling within the Secretary's exceptions. These contentions not only strain the plain meaning of the statute and fail to effect legislative intent, they run counter to *Georgetown*'s construction of clause (ii) and the Secretary's own actions. In fact, the Secretary's construction of clause (ii) in this case as requiring no more than year-end book-balancing is but one more in a long series of different interpretations by the Secretary that appear driven by the exigencies of whatever litigation is at hand.

ARGUMENT

A. The Plain Meaning Of Clause (ii), As Expressly Confirmed By *Georgetown*, Entitles Any Provider To Adjustment Of Its Reimbursement To Reflect Reasonable Costs Even If Above Regulatory Cost Limits.

The plain language of clause (ii) entitles petitioners to an adjustment of the amount provided them under the Secretary's regulations if that amount does not reimburse them for their reasonable costs. That is precisely how this Court read clause (ii) in *Georgetown*. And the Secretary's effort to restrict clause (ii) to computing the amounts due under the regulations, regardless of reasonable cost shortfalls, runs squarely counter to the language of clause (ii).[12]

[12]Clause (ii) also authorizes adjustments when payments made under the regulatory methods prove "excessive." For simplicity , we focus only on the situation where payments prove "inadequate."

1. The Plain Meaning Of Clause (ii) Authorizes Adjustments Of Reimbursements Where The Cost Limits, As Applied In A Particular Case, Produce An Underpayment.

Clause (ii) states that the Secretary shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." This sentence has a plain meaning. *See Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 669 (2d Cir. 1973) ("its plain words do not require interpretative gymnastics"). It states that a provider is entitled to have its reimbursement adjusted where the cost determination methods set forth in the regulations, including the cost limits with their exceptions, have produced an inadequate payment—where the "reimbursement produced by the methods of determining costs" turns out to be "inadequate" under the substantive standard of "reasonable costs" (§ 1395x(v)(1)(A)).

By its terms, the adjustment that clause (ii) provides for is available to any provider, not just to those providers that qualify for relief under the exceptions section of the Secretary's cost limits methodology. And the adjustment is in no way limited to mere recomputations to reconcile interim payments with the total amount due *under* the regulatory methods. Clause (ii) says explicitly that adjustment is available when the *methods themselves* produce an inadequate result.[13]

[13]Even the Secretary once recognized that this is the plain meaning. In *Humana of Illinois, Inc. v. Heckler*, No. 84-1727 (7th Cir.), consolidated with *St. James Hospital v. Heckler*, 760 F.2d 1460 (7th Cir. 1985), *cert. denied*, 474 U.S. 902 (1985), the Secretary acknowledged in his brief that clause (ii) provides "that retroactive adjustments must be made where reimbursement under the Secretary's regulations is otherwise inadequate." This argument closed with the following statement:

> To emphasize that this is indeed the interpretation of the Secretary, this brief has been signed by her legal representatives

2. *Georgetown* Expressly And Repeatedly Confirms This Plain Meaning.

In *Georgetown*, this Court rejected the Secretary's contention that clause (ii) authorized across-the-board retroactive rulemaking. 488 U.S. at 209. In so doing, the Court read clause (ii) exactly as we suggest. Thus, having noted that the cost limit regulations were among the "methods of determining costs," *id.* at 210, the Court concluded that, while the *methods* of reimbursement are not subject to retroactive alteration under clause (ii), that provision does authorize adjustments for individual providers when the generally applicable methods produce aggregate reimbursement that does not cover (or that exceeds) reasonable costs.

First, the Court said:

> we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making *case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases.* The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking.

Id. at 209 (emphasis added). Second, the Court stated that the adjustments mandated by clause (ii) "are required when, for 'a provider,' the 'aggregate reimbursement produced by the methods of determining costs' is too low or too high." *Id.* at 210. Again, in elaborating this point, the Court stated that clause (ii),

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within the Department of HHS, as well as by the Department of Justice.

See Reply Brief for Appellants/Cross-Appellees in Eighth Circuit case below, pp. 18-19 and referenced Exhibit.

> rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers. Indeed, it is difficult to see how a corrective adjustment could be made to the aggregate reimbursement paid 'a provider' without performing an individual examination of the provider's expenditures in retrospect.

Id. And finally, the Court explained:

> It is also significant that clause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. As the Secretary concedes, the cost-limit rules are one of the methods of determining costs, and the retroactive 1984 rule was therefore an attempt to change one of those methods. Yet nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

Id. at 211.

In short, to explain its holding that clause (ii) does not authorize across-the-board retroactive rulemaking (*i.e.*, adoption of new general rules or "methods" to govern past conduct), this Court in *Georgetown* construed clause (ii) according to its plain meaning—as requiring adjustments to the reimbursement of individual providers (which effect no change in the regulatory methods themselves) when the Secretary's methods produce inadequate reimbursement of reasonable costs. That is precisely the reading that the Eighth Circuit rejected in this case. Thus, far from supporting the Eighth Circuit's decision, *Georgetown* flatly contradicts that decision, and squarely supports the plain meaning interpretation we urge.

B. Congress Intended Case-By-Case Adjustments To Be Made Where The Regulatory Cost Limits Prove Inadequate In A Particular Case.

To begin with, it is obvious from the face of the statute that Congress intended that individual providers have the opportunity on a case-by-case basis to ensure that their payments reimburse them for their reasonable costs. Even aside from the plain meaning of clause (ii), this is the fundamental principle of the individualized "reasonable cost" standard of § 1395(v)(1)(A). That section expressly states that the reasonable costs of treating Medicare patients should be paid so that those costs do not end up being borne by non-Medicare patients—an inevitable consequence of refusing to allow adjustments to correct underpayments, even where they result from general regulatory limits. And that principle necessarily means that the reimbursement produced by the regulatory methods must be subject to adjustment in particular cases on the ground that the regulations produce an inadequate payment.

In 1965 when clause (ii) was enacted as part of the original Medicare statute (Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 311 (1965)), Congress clearly intended that the reasonable cost method would reimburse each provider's actual reasonable costs.[14] Nothing changed in this principle when Congress provided for the cost

[14]S. Rep. No. 404, 89th Cong., 1st Sess. 35 (1965) *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976 ("The provision in the bill for the payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization and other relevant factors."); *see also*, H.R. Rep. No. 213, 89th Cong., 1st Sess. at 31 (1965). This principle was incorporated into the Secretary's regulations at 20 C.F.R. § 405.451 (1966), *redesignated* 42 C.F.R. § 405.451 (1977), *redesignated* 42 C.F.R. § 413.9 (1986).

limits in 1972. Congress did not abandon this right of providers ultimately to obtain individualized assessments of their reasonable costs, for it left clause (ii) in tact. Instead, Congress' aim was to make the process of determining unreasonable costs more efficient and thereby strengthen the Secretary's authority to deny reimbursement for unnecessary or inefficiently incurred costs. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 40, 187 (1972); H.R. Rep. No. 231, 92d Cong., 2d Sess. 82 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069.

The legislative history makes clear that the cost limits were intended to prevent reimbursement *only* of costs resulting from "marked inefficiency" or from the provision of "excessive," luxurious services and that "only cases with extraordinary expenses would be subject to the limit." S. Rep. No. 1230, 92d Cong., 2d Sess. 187 (1972). The Finance Committee specifically acknowledged that costs of health care could vary for reasons other than inefficiency or excessive services, *e.g.*, "size of institution, patient mix, scope of services rendered or other economic factors." *Id.* Nothing suggests it intended that cost reduction efforts such as the use of part-time employees, or paying urban wages in a rural area to attract needed employees during a manpower shortage, should result in a limit on reimbursement.

The congressional committees made clear that the new cost limits were "presumptive." S. Rep. No. 1230, *supra*, at 188. They explained: "Providers would of course have the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 189. *See also* H.R. Rep. No. 231, 92nd Cong., 2d Sess. 85 (1972), *reprinted in* 1972 U.S.C.C.A.N. at 5071 (identical language).

The function of the new cost limits method was thus not to deprive providers of the opportunity for individualized relief. Instead, the cost limits methodology simply enabled inter-

mediaries to disallow costs in excess of the limits in the first instance without having to engage in a case-specific evaluation of reasonableness. Before the adoption of the cost limits, an intermediary could disallow costs as unreasonable only to the extent it could establish that a provider's costs were "substantially out of line" with comparable facilities in the same geographic area. 20 C.F.R. § 405.451(c)(2) (1967). Congress recognized that this approach placed a difficult burden of proof on the intermediary. *See* H.R. Rep. 231, *supra*, at 83, *reprinted in* 1972 U.S.C.C.A.N. at 5069-5070 ("Present law generally limits exercise of the authority to disallow costs to instances that can be specifically proven on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult."). With the cost limits in place, the provider was required to demonstrate that costs over the limits should be allowed, rather than the intermediary having to demonstrate that such costs should be disallowed. *Medical Center Hospital*, 839 F.2d at 1513.[15]

In the present case, the petitioners have justified their need for reimbursement over the cost limits. They have demonstrated that the cost limits methodology produced inadequate payments by failing to account for use of part-time employees and for the need of some rural hospitals to offer wages comparable to those paid by nearby urban hospitals. In this situation, in order to prevent non-Medicare patients from having to bear unreimbursed costs, Congress intended the Secretary to adjust the providers' aggregate reimbursement.

[15]Contrary to the government's suggestion (Br. of Resp. at 9 n.5), a plain reading of clause (ii) does not give providers an incentive to operate inefficiently "by encouraging providers to seek additional reimbursement whenever their costs exceed the Secretary's cost limits." Inefficiently incurred costs, of course, could not be reimbursed as "reasonable costs" through the adjustment process or otherwise.

C. Adjustments Under Clause (ii) Are Not Limited To Year-End Book-Balancing.

The Secretary contends that clause (ii) adjustments are limited to end-of-the-year book-balancing to reconcile the interim payments a hospital receives during a year with the amount that is due to the provider by the proper application of the reasonable cost regulations at the end of the year, after a cost report is filed.[16] Br. of Resp. at 8-9. This reading ignores the language of clause (ii), which says that an adjustment is required when the "methods of determining costs" produce an underpayment. The provision refers to *all* of the methods described in the immediately preceding sentences of § 1395x(v)(1)(A), which includes all of the cost limits and exceptions set forth in the Secretary's regulations. *See Georgetown*, 488 U.S. at 210 (section 1395x(v)(1)(A) "directs the Secretary to promulgate regulations (including cost-limit rules) establishing the methods to be used in determining reasonable costs").

Clause (ii) thus authorizes adjustments when the whole panoply of regulations produces inadequate reimbursement in a particular case. It does not apply to year-end reconciliation, for the interim payment process is not a "method" of determining reasonable cost. The interim payment process is nothing more than a mechanism to generate cash flow for

[16]The book-balancing regulations provide, in relevant part: "These regulations also provide for the making of suitable retroactive corrective adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both [the Medicare program] and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year." 20 C.F.R. § 405.451(b)(1)(1967), *redesignated* 42 C.F.R. § 405.451(b)(1)(1977), *redesignated* 42 C.F.R. § 413.9(b)(1986). *See also* 20 C.F.R. § 405.454(f)(1967), *redesignated* 42 C.F.R. § 405.454(f)(1977), *redesignated* 42 C.F.R. § 413.64(f)(1986).

providers until the reasonable costs of providing services can be determined at the close of the year, and has no function or relationship to the process of determining whether the costs claimed on the annual cost report are reasonable. While this year-end reconciliation process may involve a retroactive adjustment, it does *not* accomplish the central test that is required by the plain language of clause (ii): to determine on a case-by-case basis whether the aggregate reimbursement produced by the *methods themselves* is sufficient to reimburse an individual provider for its "reasonable costs."

Indeed, year-end book-balancing is not the subject of clause (ii) at all. It is 42 U.S.C. § 1395g (1992), entitled "payments to providers of services," that addresses, in detail, the entire subject of interim payments and end-of-year book-balancing.[17] The Secretary's reading would thus not only run counter to the test of clause (ii) but render it largely redundant, contrary to a cardinal principle of statutory construction. *See, e.g., United States v. Nordic Village, Inc.*, 112 S. Ct. 1011, 1015 (1992); *Colautti v. Franklin*, 439 U.S. 379, 392 (1979).[18]

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[17] Subsection (a) of § 1395g expressly provides for *both* interim payments during the year *and* end-of-year reconciliation:

> (1) Determination of amount. The Secretary shall periodically determine the amount which should be paid under [Part A] to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, *with necessary adjustments on account of previously made overpayments or underpayments*; ... [Emphasis added.]

[18] In the course of its discussion, the *Georgetown* Court noted that in the past the *Secretary* had interpreted clause (ii) to require only year-end reconciliation. *Id.* at 211 and n.2. It made this statement only as justification for not deferring to the Secretary's position in *Georgetown* that clause (ii) authorized retroactive rulemaking, not to endorse the Secretary's interpretation that clause (ii) requires no more than year-end book-balancing. The Court in *Georgetown* did not examine the precise contours and operation of the book-balancing regulations to determine whether they were in fact a valid implementation of clause (ii). Nor did the Court analyze whether the proper authority for the book-balancing regulations was 42 U.S.C. § 1395g, which provides for both interim payments and year-end reconciliation. Those issues were not before the Court. Accordingly, the Court's discussion of the book-balancing regulations in *Georgetown* at most is dicta and cannot be construed as approval of the Secretary's limited "book-balancing" construction of clause (ii), for such a reading would contradict the point repeatedly made in *Georgetown's* text—that clause (ii) authorizes adjustments *beyond* the regulatory limits.

D. The Exceptions Provided In The Cost Limits Regulation Are Not The Mechanism To Implement Clause (ii).

As part of the cost limits method at § 405.460, the Secretary provided for certain very narrow exceptions to the limits. In his Brief in Response to the Petition for Certiorari, the Secretary argues that these exceptions fully satisfy his duty to make the cost limits presumptive. Br. of Resp. at 10. He also argued, in *Medical Center Hospital v. Bowen*, 839 F.2d 1504, 1511 (11th Cir. 1988), that providing a process for selective exceptions to the limits satisfies his duty under clause (ii) for retroactive corrective adjustments.

These arguments fail for two reasons. First, the exceptions themselves are part of the cost limits regulation. The regulation, including the exceptions thereto, constitute one of the "methods" of determining reasonable costs that is subject to the overriding requirement that "corrective adjustments" be made *whenever* the actual aggregate reasonable costs exceed the reimbursement due under an established method. *Regents of the University of California v. Heckler*, 771 F.2d at 1190-91.

Second, the exceptions provision of the cost limit regulations cannot satisfy the mandate in clause (ii) for "corrective adjustments" because relief under the provision would then be limited to those providers with reimbursement shortfalls falling

within the exceptions' narrow scope.[19] Both the plain language of clause (ii) and the legislative history of the cost limits, *supra* p. 16, indicate that, owing to their presumptive nature, *any* provider may receive reimbursement over the limits if the provider can justify the reasonableness of its costs. *See Medical Center Hospital*, 839 F.2d at 1511 ("We can imagine myriad situations where resort to the Secretary's [cost limits] exceptions process would not result in the provider receiving the full reimbursement to which it is entitled under the statute.").

Moreover, the exact wording of clause (ii) requires the Secretary to provide suitable adjustments for "a provider" of services. The Secretary would construe this phrase to mean only "some" providers, *i.e.*, only those qualifying under the narrow exceptions that are part of the cost limits method. No support exists for such an interpretation which strains all accepted rules of statutory construction.

Thus, exceptions to the cost limits cannot be limited to those few situations provided in the regulations at 42 C.F.R. § 405.460. Rather, owing to their presumptive nature, the cost limits may be rebutted by any provider that can demonstrate that the cost limits methodology produced an incorrect result and that its incurred costs are reasonable.

[19]The parties agree that none of the regulatory exceptions to the cost limits provide relief to the Hospitals. Pet. App. at 4a. The petitioners' fiscal intermediary stated to one of the petitioners, "As far as the [cost limits] exceptions noted on page three of [HCFA's] letter [denying relief for the wage index issues] go - I haven't found any in Nebraska that HCFA will accept." A.R. 162. Indeed, HCFA flatly stated that a challenge to the cost limit methodology "is beyond the scope of any basis for an exception provided under § 405.460(f) of the Medicare regulations." A.R. 164.

E. Deference To The Secretary Cannot Justify Reading Clause (ii) Contrary To Its Language And Purpose.

1. To the extent that the Secretary claims that its year-end book-balancing regulation embodies an interpretation of clause (ii) to which deference is owed, that position is wrong on several grounds. For one thing, the regulation cannot control where it is contrary to the meaning of the statute as drawn using the usual methods of statutory construction, including its language and purpose. *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984); *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981); *SEC v. Sloan*, 436 U.S. 103, 117-118 (1978); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 745-746 (1973). This is especially so where the statute has already been authoritatively construed by this Court, as clause (ii) was in *Georgetown*. *See Lechmere, Inc. v. NLRB*, 112 S. Ct. 841, 847-48 (1992); *Maislin Industries, U.S., Inc. v. Primary Steel, Inc.*, 110 S. Ct. 2759, 2768 (1990).

In fact, treating the book-balancing regulations as embodying an authoritative interpretation of clause (ii) would make clause (ii) mere surplusage. As set forth above, the whole subject of year-end book-balancing is addressed by § 1395g, not by clause (ii). *See* page 20, *supra*.

2. The inconsistency of the Secretary's positions on the meaning of clause (ii) also undermines any claim to deference the Secretary may advance. *Pauley v. Bethenergy Mines, Inc.*, 111 S. Ct. 2524, 2535 (1991). While the Secretary has here construed clause (ii) as authorizing only year-end book-balancing, he has taken different "convenient litigating position[s]" in other cases. *Georgetown*, 488 U.S. at 213.

(a) In *Georgetown*, the Secretary argued that clause (ii) empowers him to issue legislative across-the-board rules with retroactive effect.[20] 488 U.S. at 209.

[20]*Accord, Medical Center Hospital*, 839 F.2d at 1513 n.14, where the Secretary was unwilling to concede that he has *ever* interpreted clause (ii) to require any provider-specific adjustments, presumably including year-end reconciliations.

(b) In *Medical Center Hospital*, the Secretary argued that clause (ii) is satisfied by the so-called cost limits "exceptions process" established in 42 C.F.R. § 405.460. 839 F.2d at 1511.

(c) In *Mercy Community Hospital v. Blue Cross Association/ Blue Cross of Florida, Inc.*, HCFA Dep. Admin. Dec., [1983-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,316 at 9542 (Nov. 4, 1982), the Secretary argued that clause (ii) authorized the regulation at 42 C.F.R. § 405.415(f), which "provides for a retroactive corrective adjustment [for individual providers] when a depreciable asset is sold at a gain or a loss," and in *Springdale Convalescent Center*, 545 F.2d at 954, he argued it authorized the regulation at § 405.415(d)(3), which permits Medicare to recoup the difference between accelerated and straight-line depreciation when a provider leaves the Medicare program.

(d) In *Humana of Illinois, Inc. v. Heckler*, No. 84-1727 (7th Cir.), consolidated with *St. James Hospital v. Heckler*, 760 F.2d 1460 (7th Cir. 1985), *cert. denied*, 474 U.S. 902 (1985), the Secretary stated in his brief that clause (ii) provides "that retroactive adjustments must be made where reimbursement under the Secretary's regulations is otherwise inadequate." *See* n. 10, *supra*.

Most significantly, even after *Georgetown* the Secretary has failed to follow his current interpretation that year-end book-balancing is the only retroactive adjustment permitted by clause (ii). In *Sutter Community Hospitals, et al. v. Heckler*, No. 5-82-204 (E.D. Cal. 1984), *aff'd*, Nos. 84-1900 and 84-1852 (9th Cir. 1985), the court held that clause (ii) required that the providers be given an opportunity to demonstrate that their costs in excess of the cost limits were reasonable, and remanded the case to the Provider Reimbursement Review Board for a hearing. At the conclusion of the hearing process where the providers presented evidence to support the reasonableness of their costs in excess of the limits, the PRRB ruled in favor of

the providers. PRRB Decisions Nos. 89-D69/89-D73, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶¶ 38,228-38,229 (September 28, 1989).

Nearly a year after *Georgetown* was decided, the HCFA Administrator, as the Secretary's delegate, affirmed the PRRB decisions in the *Sutter* cases. HCFA Administrator Decision, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,279 (Nov. 27, 1989). His affirmance assumed the authority of the PRRB to make adjustments to the providers' costs. He did not have to do so, if he interpreted *Georgetown* to hold that clause (ii) only required book-balancing. *See Chicago and North Western Transportation Co. v. United States*, 574 F.2d 926, 930 (7th Cir. 1978) (under law of the case doctrine, an administrative agency is bound on remand to apply principles laid down by court unless an intervening decision of the Supreme Court is inconsistent with remand order).[21]

3. Finally, any claim to deference to the Secretary's restrictive view of clause (ii) is undermined by the fact that there is a regulatory procedure designed for, and used for, the making of adjustments to correct inadequacies resulting from application of the regulatory methods. Thus, the adjustments can be and are made through the Provider Reimbursement Review Board ("PRRB") adjudicatory process. 42 C.F.R. §§ 405.1801-405.1890 (1991).

Section 1395oo(d) of the statute authorizes the PRRB to address claims for such adjustments when it authorizes the PRRB "to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost reports . . . even though such matters were not considered by

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[21] Even in a non-litigation context following *Georgetown*, the Secretary acknowledged that clause (ii) requires reimbursement of costs in excess of the cost limits, rather than mere book-balancing. *See* HCFA Ruling 89-2, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,236 (October 31, 1989).

the intermediary." Indeed, in *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 406 (1988), the Court's description of the PRRB's authority under § 1395oo(d) is expansive:

> This language allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation prescribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.

That authority is sufficient to allow the PRRB directly to award an adjustment departing from the regulatory cost limits, notwithstanding the regulatory bar on the PRRB invalidating the Secretary's regulations. 42 C.F.R. § 405.1867. That bar, as this Court suggested in *Bethesda*, 485 U.S. at 406, is best read as forbidding the PRRB "to declare regulations invalid." A decision by the PRRB that a retroactive adjustment is warranted in a particular situation where presumptive cost limits result in inadequate reimbursement would not invalidate the regulations as generally applied.[22]

Significantly, the PRRB was created in the same legislation that authorized the cost limits. Pub. L. No. 92-603, §§ 223, 243, 86 Stat. 1329 at 1627, 1661 (1972). In addition, the timing of the PRRB regulations suggest that the PRRB is the regulatory mechanism to implement clause (ii). In 1973 the Second Circuit held in *Kingsbrook*, 486 F.2d at 669, that

[22]The Court of Appeals stated that any relief to the petitioners would constitute a "second bite of the apple," where the Court upheld the validity of the cost limits regulation. Pet. App. 149. This statement ignores the fact that clause (ii) requires such retroactive adjustments where *valid* methods of determining costs result in inadequate reimbursement.

clause (ii) required regulations for retroactive adjustments "to correct flaws in the aggregate reimbursement to which a provider is entitled due to an erroneous method of determining reimbursable costs." Having searched "in vain for such regulations," the *Kingsbrook* Court ordered the Secretary "to promulgate regulations consistent with the interpretation of section 1395x(v)(1) that we have announced." *Id.* at 670. The PRRB regulations, expressly invoking § 1395x(v) as well as § 1395oo as authority, were promulgated the next year. 39 Fed. Reg. 34515 (1974). The Secretary has promulgated no other regulations since that time in response to the *Kingsbrook* mandate that provide a process for individualized adjustments for any provider.

Against this background, it is hardly surprising that the PRRB has actually served as the mechanism for clause (ii) adjustments in a number of cases. *See Medical Center Hospital v. Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Sutter Community Hospitals, et al. v. Heckler*, No. 5-82-204 (E.D. Cal. 1984), *aff'd*, Nos. 84-1900 and 84-1852 (9th Cir. 1985). And in the *Sutter* cases, as discussed at p. 25, *supra*, the Administrator of HCFA affirmed the PRRB decisions which granted an adjustment from the results of applying the Secretary's cost limit regulations.

F. The Relief Petitioners Seek Would Not Amount To Retroactive Rulemaking.

The Eighth Circuit suggested that the relief petitioners seek would amount to retroactive rulemaking. Pet. App. 13a. Presumably, the court of appeals reasoned that, since *Georgetown* said that clause (ii) does not authorize such rulemaking, petitioners' reading of clause (ii) must be rejected. This is plainly wrong: the adjustment petitioners seek is not "rulemaking."

As this Court (and the concurring opinion) in *Georgetown* made unmistakably clear, there is a fundamental and dispositive distinction between rulemaking and adjudication. 488 U.S. at 209-210 (Scalia, J., concurring). What clause (ii) does not authorize, as *Georgetown* held, is the making of new general rules to govern past conduct. But petitioners do not seek any such new rules. Rather, they seek nothing more than an individualized *adjudication*. The effect of this determination is not to promulgate a new legislative rule or to invalidate the regulatory methods as valid *general* rules.

Moreover, all that petitioners seek is their rights under the law as it always existed for the 1980-1983 cost years: *i.e.*, they claim their right—not just under the regulations, but under the necessarily superior statutory "reasonable cost" standard—to the correct level of reimbursement. Thus, petitioners' reading of clause (ii) does not authorize imposition of a standard on this particular case that was not in existence at the time the services were delivered. The effect is simply to apply then-governing law ("reasonable cost") to one case.

Finally, of course, once the case-specific nature of the determination is recognized, any question about retroactivity is irrelevant. Clause (ii) expressly authorizes individual "retroactive corrective adjustments." Accordingly, the *Georgetown* principle disfavoring retroactive rulemaking offers no reason whatever for reading clause (ii) contrary to its plain meaning.

CONCLUSION

The petitioners request that the decision of the court of appeals be reversed and that this case be remanded to the Provider Reimbursement Review Board where the petitioners shall have the opportunity to demonstrate that their costs in excess of the cost limits are reasonable.

Respectfully submitted,

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Supreme Court, U.S.
FILED
DEC 30 1992
OFFICE OF THE CLERK

No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether a health care provider may invoke 42 U.S.C. 1395x(v)(1)(A)(ii), which authorizes regulations providing for the making of "suitable retroactive corrective adjustments" to Medicare reimbursements, to obtain reimbursement in excess of valid regulatory cost limits that are specifically authorized by Section 1395x(v)(1)(A).

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In the Supreme Court of the United States

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GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS

v.

LOUIS W. SULLIVAN, SECRETARY OF
HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-17a) is reported at 952 F.2d 1017. The decision of the district court (Pet. App. 19a-36a) is not officially reported.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. A petition for rehearing was denied on February 7, 1992. Pet. App. 18a. On April 28, 1992, Justice Blackmun extended the time for filing a petition for a writ of certiorari to and including July 6, 1992. The petition was filed on June 26, 1992, and was granted on October 13, 1992. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program, enacted in 1965 as Title XVIII of the Social Security Act,[1] provides for payment of certain medical expenses on behalf of eligible aged and disabled persons. Under Part A of the Medicare program, hospitals, skilled nursing facilities and home health agencies are reimbursed for primary care that they provide to Medicare beneficiaries. See 42 U.S.C. 1395c to 1395i-4 (1988 & Supp. II 1990). The Act directs the Secretary of Health and Human Services to "periodically determine the amount which should be paid under [Part A] to each provider" for services furnished to Medicare beneficiaries, and to pay the amounts so determined to the provider at least monthly, with adjustments necessary to account for past overpayments and underpayments. 42 U.S.C. 1395g. Such interim payments are made on the basis of the provider's estimated costs. See 42 C.F.R. 413.64(e) and (f). At the end of the cost year, the provider submits a cost report, which furnishes the basis for the Secretary's fiscal intermediary to determine the provider's actual reimbursable costs for that year. See 42 C.F.R. 405.1803, 413.20(b), 413.24(f); see also *id.* §§ 413.9(b), 413.64(f).[2]

For the years at issue, a Part A provider was reimbursed for the "reasonable cost" of the services it furnished or its "customary charges" for those services, whichever was less. 42 U.S.C. 1395f(b)(1) (1982).[3]

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[1] Pub. L. No. 89-97, 79 Stat. 291, codified at 42 U.S.C. 1395 *et seq.*

[2] The Part A program is administered on the Secretary's behalf by fiscal intermediaries (typically private insurance companies), whose decisions on cost reports may be appealed to the Provider Reimbursement Review Board. See 42 U.S.C. 1395*oo*; *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399 (1988).

[3] Beginning on October 1, 1983, most hospital inpatient services under Part A have been reimbursed in accordance with fixed rates

Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and it directs the Secretary of Health and Human Services to promulgate regulations establishing the method or methods for determining reasonable cost. 42 U.S.C. 1395x(v)(1)(A). The same section also requires the regulations to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) [hereinafter "clause (ii)"]. The Secretary has issued comprehensive regulations establishing principles of reasonable cost reimbursement. See 42 C.F.R. Pt. 413. As required by clause (ii), those regulations provide for retroactive corrective adjustments after the provider has submitted its final cost report for the fiscal year. "The retroactive adjustment will represent the difference between the amount received by the provider [in interim payments] during the year for covered services * * * and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of

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prescribed under the Prospective Payment System (PPS). See 42 U.S.C. 1395ww(d); 42 C.F.R. Pt. 412. The PPS system is not at issue here. PPS does not apply, however, to skilled nursing facilities or home health agencies. We have been informed by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services that there are 6,211 skilled nursing facilities and 6,009 home health care agencies currently participating in the Medicare program. Those providers receive approximately $7.65 billion annually in Medicare payments, and HCFA estimates that approximately $400 million in claims are disallowed each year as a result of applicable cost limits. In addition, 2,832 hospitals are excluded from PPS and are instead subject to rate-of-increase limits, similar to the Secretary's cost limits, under 42 U.S.C. 1395ww(b) (1988 & Supp. II 1990). See 42 C.F.R. 412.22-412.23 (1991).

services furnished to beneficiaries during the year." 42 C.F.R. 413.9(b); see also *id.* § 413.64(f).

At the inception of the Medicare program, essentially all of a provider's "actual costs" were "allowable," however widely they might have varied among providers or even among a single provider's patients, so long as the costs were not "substantially out of line" with those of similar institutions. See, *e.g.*, 20 C.F.R. 405.451(c) (1967).[4] Such "allowable" costs were apportioned between a provider's Medicare and non-Medicare patients in order to determine the "reasonable cost" of services reimbursable under the Medicare program. See *id.* §§ 405.403, 405.452. Congress soon became concerned, however, that in practice the "reasonable cost" standard allowed providers to recover whatever costs they incurred, no matter how inefficiently. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-85 (1971); S. Rep. No. 1230, 92d Cong., 2d Sess. 188-189 (1972). Congress responded to that problem in 1972 by revising 42 U.S.C. 1395x(v)(1)(A) to tighten the statutory definition of "reasonable cost" and to authorize the Secretary to promulgate regulations establishing limits ("based on estimates of the costs necessary in the efficient delivery of needed health services") on the costs that would be "recognized as reasonable" for purposes of Medicare reimbursement. Pub. L. No. 92-603, § 223, 86 Stat. 1393-1394.

In 1974 the Secretary promulgated the first regulations establishing cost limits for certain items and services, together with an initial schedule of per diem limits ap-

[4] The regulations concerning determination of costs reimbursable under Medicare were originally codified at 20 C.F.R. 405.401-405.454 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405, see 42 Fed. Reg. 52,826 (effective October 1, 1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (effective October 1, 1986). We give parallel citations only when it seems useful to do so. The key provisions cited herein have remained substantially unchanged since their original promulgation.

plicable to inpatient "general routine service costs." 39 Fed. Reg. 20,164, 20,168-20,170 (1974); see 20 C.F.R. 405.460 (1975), redesignated as 42 C.F.R. 413.30. The cost limits in force have been updated annually since then. See, *e.g.*, 57 Fed. Reg. 29,410 (1992) (home health agencies); 57 Fed. Reg. 46,177 (1992) (skilled nursing facilities). The limits are based on provider classifications and other factors the Secretary finds "appropriate and practical," including type of service furnished, geographical area, institutional size, nature and mix of services furnished by the provider, and patient mix. See 42 C.F.R. 413.30(b).

The regulations establish a general rule that reimbursable costs may not exceed the applicable cost limits. 42 C.F.R. 413.30(a)(2). The regulations do, however, specify circumstances in which the limits may be exceeded. For example, an exemption from the cost limits may be granted to new providers, sole community hospitals, and small rural hospitals. 42 C.F.R. 413.30(e). In addition, an exception may be granted in particular situations involving, *inter alia*, atypical services, extraordinary circumstances beyond the provider's control, or essential community hospital services. 42 C.F.R. 413.30(f).[5]

2. During the cost years at issue in this case, the Secretary classified providers according to two criteria for cost limit purposes: (a) an area wage index, and (b) location within or without a Standard Metropolitan Statistical Area (SMSA).

[5] Exceptions operate differently from exemptions. Exemptions attach to the operations of any provider that falls into an exempt category. Exceptions involve careful evaluation of particular circumstances, and lead to an adjustment "only to the extent the [excess] costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified" by program administrators. 42 C.F.R. 413.30(f).

a. The Secretary adopted the wage index system in 1979 as a way of adjusting for variations in wage levels among geographical areas. 44 Fed. Reg. 11,612, 11,613 (1979).[6] Initially, the Secretary relied for this index on data obtained from the Bureau of Labor Statistics (BLS). *Ibid.* The BLS data were criticized because, among other things, they failed to account for local variations in the proportion of part-time to full-time workers. The Secretary concluded, however, that the BLS statistics were the "most reliable data available" at the time. See, *e.g.*, 45 Fed. Reg. 41,868, 41,871 (1980); 49 Fed. Reg. 234, 257 (1984).[7]

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[6] Prior to adoption of a wage index, the Secretary had used per capita income in the area to adjust for variations in wage levels among providers. Most public comments on the proposed wage index agreed that such an index was an improvement over the use of per capita incomes. 44 Fed. Reg. 31,806, 31,807 (1979).

[7] Petitioners complain (Pet. Br. 5 & n.4) that distortions in the BLS data were "known by the Secretary from the earliest use of the wage index." That assertion is irrelevant here, given that petitioners were unsuccessful below in their challenge to the reasonableness of the Secretary's cost limits, including the wage index (see page 10, *infra*), and have not renewed that challenge in this Court. In any event, the Secretary has maintained only that the BLS data were adequate, not that they were perfect. The July 1981 Memorandum prepared by the Health Care Financing Administration which petitioners cite (Pet. Br. 5 n.3) noted that although the "BLS data cause unavoidable distortions affecting the accuracy of the index for some locales," they represent the "best source currently available" because "[t]here is no other data source of national scope which will eliminate the[se] index distortions * * *." Pltf's Mot. for Summ. Jdgmt., Exh. D, at 1, 5. Moreover, the Secretary "proposed in 1981 to develop an appropriate database [to take account of part-time workers] by modifying the Medicare cost report, but the proposal was delayed in part because of opposition from the hospital industry." *Mt. Diablo Hospital* v. *Sullivan*, 963 F.2d 1175, 1180 (9th Cir. 1992), petition for cert. pending, No. 92-720. See also 49 Fed. Reg. 27,438, 27,439 (1984) (in 1983, HCFA established a joint working group of participants from various state associations to evaluate alternatives to the BLS data).

In 1984, Congress directed the Secretary to conduct a wage index study to adjust for variations in the numbers of part-time employees. Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081. Based on data obtained through that study, the Secretary revised the wage index in 1986 to account for part-time employees. 51 Fed. Reg. 16,772 (1986). Congress subsequently directed that the revised index be applied to patient discharges occurring on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156.

b. As noted above, during the years at issue providers were also classified demographically. In 1974, the Secretary decided to use a provider's location within a Standard Metropolitan Statistical Area "as a proxy for an urban location." Locations not within an SMSA[8] were considered "nonurban" or rural. 39 Fed. Reg. 20,168 (1974). Because it is generally more expensive to operate a hospital in an urban area than in a rural one, 44 Fed. Reg. 11,613 (1979), HCFA set a higher cost limit for providers within an SMSA than for providers outside an SMSA.

3. Petitioners are six rural Nebraska hospitals whose costs exceeded the applicable cost limits for some of the years between 1980 and 1984. On review of their cost reports for those years, petitioners challenged the validity of the applicable cost limits. They also asked the Secretary's Provider Reimbursement Review Board (PRRB) for a "suitable retroactive corrective adjustment," citing clause (ii) of 42 U.S.C. 1395x(v)(1)(A) as authority for an individualized departure from the cost limits, even though they did not qualify for an exemption from or

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[8] In 1983, the Office of Management and Budget changed this terminology to Metropolitan Statistical Area (MSA). For convenience, we will continue to use the term SMSA here.

exception to those limits under the regulations. In particular, petitioners claimed that the cost limits did not properly account for the high proportion of part-time employees in their work force, and did not permit rural hospitals to show that they incurred costs similar to those of urban hospitals. The PRRB, which is bound by the Secretary's regulations, concluded that it lacked authority over petitioners' legal challenges, thus allowing petitioners to seek immediate judicial review. Pet. App. 37a-54a; 42 U.S.C. 1395*oo*(f)(1).

Petitioners then filed this suit in the United States District Court for the District of Nebraska. They contended (1) that the wage index was arbitrary and capricious, because it was "calculated without regard to the effect of the use of part-time or full-time employee data"; (2) that classification of hospitals as rural or urban "without possibility of an exception" had "no rational basis"; and (3) that they were in any event entitled by clause (ii) of 42 U.S.C. 1395x(v)(1)(A) to relief in the form of "suitable retroactive corrective adjustments to the costs limits." J.A. 13-15. Petitioners requested an order declaring the applicable cost limit schedules "illegal on their face" or, in the alternative, "an order requiring the Secretary to reimburse [petitioners] for their reasonable costs for the years under appeal without regard to the cost limits." J.A. 18-19.[9]

The district court granted summary judgment for petitioners. Pet. App. 19a-36a. The court did not address petitioners' facial challenge to the wage index and rural/urban classifications used in establishing the cost limits. Rather, it agreed with petitioners that "the Secretary must allow [them] an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined [to be] reasonable under the cost limits schedule." *Id.* at 26a. Adhering to the Eighth Circuit's decision in *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (1987), the district court held that "[t]he Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs." Pet. App. 29a. It accordingly rejected the Secretary's contention that clause (ii) "only authorizes a year-end 'book balancing' adjustment" to ensure that the provider "receives what is due under the cost limits as applied." Pet. App. 27a-28a, 31a-33a. The court remanded the case to the Secretary for "consideration of [petitioners'] reasonable expenses in excess of the cost limit rules in effect for the years under appeal." *Id.* at 32a.

4. The court of appeals reversed. Pet. App. 1a-17a. The court agreed with the Secretary that its prior interpretation of clause (ii) in *St. Paul-Ramsey* was effectively overruled by this Court's decision in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988). Pet. App. 11a. Under *Georgetown*, the panel explained, "clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts" disbursed to providers. *Id.* at 12a. Accordingly, clause (ii) "merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Ibid.* On this basis, the court rejected petitioners' claims for additional reimbursement under clause (ii), holding that the relief petitioners sought—to have "the methodology changed to correct

[9] A provider's reimbursable costs for its cost period ending after September 30, 1982 (at issue for each petitioner in this case) determines the provider's "base year" costs under the Prospective Payment System. See note 3, *supra*. Base year costs in turn affect the provider's reimbursable costs for each of the first four PPS years. If petitioners are successful in obtaining additional reimbursement for 1982 in this case, they are entitled to an upward adjustment in their "hospital-specific" reimbursement rate under PPS for the four subsequent years. J.A. 16-19.

what they believe are inequalities in the system"—would "amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown*, is invalid." *Id.* at 13a. Such a methodological change would constitute a "second bite at the apple" on claims for reimbursable costs, a result that clause (ii) "does not allow." *Id.* at 13a-14a (citing *Hennepin County* v. *Sullivan*, 883 F.2d 85, 92 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990), and *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990)).

The court of appeals also upheld the validity of the Secretary's cost limit regulations, finding "nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a. The court explained that "[b]oth the wage index and the rural/urban distinction were based on objective data and regulations," and it rejected petitioners' argument that the regulations' failure to account for part-time workers and the use of SMSA criteria to designate "urban" hospitals rendered the limits invalid. *Ibid.*

SUMMARY OF ARGUMENT

In the courts below, petitioners challenged the validity of the cost limits prescribed by the Secretary for the years in question. The court of appeals rejected that challenge, and petitioners do not renew it here. Instead, petitioners seek to use clause (ii) of 42 U.S.C. 1395x (v)(1)(A) to achieve the same result. Petitioners' expansive interpretation of clause (ii) is at odds, however, with the language of the clause, the statutory language as a whole, the history and contemporaneous interpretation of the relevant provisions, and this Court's decision in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988). Petitioners' approach would undermine the efficacy of the cost limits specifically authorized by Congress, and convert the orderly reimbursement scheme that now exists into an endless series of *ad hoc* determinations in derogation of otherwise valid regulatory standards.

The plain language of clause (ii) supports the Secretary's interpretation of its function. The clause's "retrospective" and "corrective" thrust are consistent with the Secretary's view that it contemplates adjustments of a "book-balancing" nature, rather than the type of broad exceptions (with prospective as well as retrospective practical effect) sought by petitioners. Similarly, the Secretary's interpretation—unlike that advanced by petitioners—respects the clause's focus on the aggregate reimbursement produced by the applicable cost determination methods, the relationship of the clause (ii) adjustment to the interim payment system established under 42 U.S.C. 1395g, and the statutory command that validly promulgated cost limits be "recognized as reasonable" for Medicare purposes. At the very least, the Secretary's implementation of clause (ii), through regulations that form an integral part of the complex regulatory scheme mandated by the statute to give content to the "reasonable cost" standard, represents a permissible construction of the statute and is entitled to judicial deference.

The meaning of clause (ii) that is evident from its language and the text of 42 U.S.C. 1395x(v)(1)(A) as a whole is confirmed by its history and contemporaneous interpretation. The legislative history of clause (ii) itself suggests no reason for departing from the interpretation required by its text. Moreover, the initial regulations implementing the Medicare reimbursement provisions, promulgated little more than a year after the statute's enactment, reflect in their language and structure precisely the "book-balancing" interpretation of clause (ii) that the Secretary relies on here. This interpretation was also brought to the attention of Congress within a year of the statute's enactment. From the outset, clause (ii) was interpreted as an important but

limited provision relating to year-end accounting under the reimbursement provisions; there was no suggestion of the different and far more expansive role urged by petitioners.

Congress toughened the governing principles of cost reimbursement in 1972, in part by authorizing the Secretary to promulgate "limits on the * * * incurred costs * * * to be recognized as reasonable" for Medicare purposes. Petitioners concede that they do not qualify for any exemption or exception from the cost limits thereafter promulgated by the Secretary. They contend, however, that clause (ii) confers on them a substantive right to individual, *ad hoc* adjudication of their claim that certain of their costs were "reasonable," and hence reimbursable without regard to the otherwise valid cost limit rules. In fact, petitioners are merely trying to use clause (ii) to fight again the battle that they lost when the court of appeals correctly refused to invalidate the cost limits applicable to petitioners for the years in issue.

Petitioners' reliance on clause (ii) in this case is foreclosed, however, by this Court's decision in *Bowen* v. *Georgetown University Hospital*, *supra*. In *Georgetown*, the Court rejected an interpretation of clause (ii) that would have authorized retroactive, substantive cost reimbursement regulations. The Court's discussion of clause (ii) makes clear that the clause plays only the more limited role assigned to it by the initial regulations—which the Court cited with approval—and advanced by the Secretary here. *Georgetown* specifically states that clause (ii) does not permit changes in the methods, including costs limits, used to compute "reasonable costs," and disapproves exactly the sort of wholesale retroactive revision of cost determination methods that would be the practical effect of accepting petitioners' position.

Finally, petitioners make much of the fact that the Secretary's position on the meaning of clause (ii) has varied at times between the inception of the program and the decision in *Georgetown*. The Secretary's varying position stemmed largely, however, from the disarray that prevailed among the lower courts on this issue for some time before *Georgetown*. Since *Georgetown*, and taking into account this Court's authoritative construction of the statute in that case, the Secretary has returned to his original construction. The fact that the Secretary once took a somewhat broader view does not affect the validity of his current position, or the deference due it from the courts.

ARGUMENT

A MEDICARE PROVIDER CANNOT CIRCUMVENT VALID COST LIMITS IN THE SECRETARY'S REIMBURSEMENT REGULATIONS BY INVOKING THE PROVISION IN CLAUSE (ii) OF 42 U.S.C. 1395x(v)(1)(A) FOR "SUITABLE RETROACTIVE CORRECTIVE ADJUSTMENTS"

In the courts below, petitioners challenged the cost limits prescribed by the Secretary for the years in question on the ground that the wage index and SMSA classifications on which the limits were based did not fully recognize the costs petitioners reasonably incurred. The court of appeals rejected that challenge, and petitioners do not renew it here. Accordingly, as the case comes to this Court, the cost limits must be regarded as entirely lawful in their application to petitioners for the years in question.

Petitioners now seek through clause (ii) of 42 U.S.C. 1395x(v)(1)(A) precisely the same result—avoidance of the cost limits—that outright invalidation of those limits would have accomplished. They contend that the requirement in clause (ii) that the Secretary's "reasonable cost" regulations provide for "suitable retroactive corrective adjustments" in certain circumstances entitles them to reimbursement in excess of the valid cost limits promulgated pursuant to the immediately preceding sentence of 42 U.S.C. 1395x(v)(1)(A). Petitioners' expan-

sive vision of clause (ii) is inconsistent with the carefully circumscribed language of clause (ii), the text of 42 U.S.C. 1395x(v)(1)(A) as a whole, the history and contemporaneous interpretation of those provisions, and this Court's decision in *Bowen* v. *Georgetown University Hospital*, *supra*. In addition, the approach petitioners urge would undermine the efficacy of the cost limits that Congress specifically authorized. The result would be to convert the existing system of orderly reimbursement within the regulatory framework implementing the statutory "reasonable cost" standard into an endless series of *ad hoc* determinations in derogation of otherwise valid regulatory standards.

A. The Text Of The Act Supports The Secretary's Implementation Of Clause (ii) Through Regulations That Provide Only For A Year-End, "Book-balancing" Adjustment Of A Provider's Total Reimbursement Within The Framework Of The Cost Limit Regulations

"The starting point in statutory interpretation," of course, "is 'the language [of the statute] itself.'" *Ardestani* v. *INS*, 112 S. Ct. 515, 519 (1991) (quoting *United States* v. *James*, 478 U.S. 597, 604 (1986)). If "Congress has directly spoken on the precise question at issue" and "the intent of Congress is clear, that is the end of the matter"; "the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). See also *Estate of Cowart* v. *Nicklos Drilling Co.*, 112 S. Ct. 2589, 2594 (1992). On the other hand, "[i]f * * * Congress has not directly addressed the precise question at issue," the question is "whether the agency's answer is based on a permissible construction of the statute," for "considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer." *Chevron*, 467 U.S. at 843-844.

Such deference is especially appropriate in this case, because the Social Security Act (of which the Medicare Act is a part) "is among the most intricate ever drafted by Congress," and Congress accordingly has "conferred on the Secretary exceptionally broad authority to prescribe standards" by regulation. *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981); see 42 U.S.C. 1302, 1395x(v)(1)(A), 1395hh. Finally, of course, "a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context." *King* v. *St. Vincent's Hospital*, 112 S. Ct. 570, 574 (1991) (citations omitted).

The foregoing principles support the validity of the Secretary's regulations implementing clause (ii). Under those regulations, the adjustments contemplated by clause (ii) are essentially of a "book-balancing" nature, reflecting the difference between the total of the interim payments received by the provider during the year, based on its estimated costs, and the actual costs the provider is found at the close of the year to have properly incurred under the Secretary's regulations. 42 C.F.R. 413.9(b), 413.64(f). Conversely, the text of the Act refutes petitioners' interpretation of clause (ii), under which a provider would be entitled to seek reimbursement in excess of the valid cost limits prescribed in the regulations simply by claiming that its higher costs satisfied some vague standard of "reasonableness."

Clause (ii) is contained in Subsection (1)(A) of Section 1861(v) of the Act, which sets forth the statutory definition of "reasonable costs." 42 U.S.C. 1395x(v). Subsection (1)(A) states in pertinent part:

> The reasonable cost of any services * * * shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included * * *. Such regulations * * * may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items

> or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health serviecs to individuals covered by the insurance programs established under [Medicare] * * *. Such regulations shall * * * (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

This language supports the limited role of clause (ii) reflected in the Secretary's regulations, and undermines petitioners' far more expansive and open-ended vision of the clause.

First, the entire thrust of clause (ii) is retrospective, indicating that it comes into play only at the end of an accounting period and therefore serves an accounting purpose. Thus, clause (ii) refers to "retroactive" adjustments, for a "fiscal period," where aggregate reimbursement "proves" to be either inadequate or excessive. The Secretary's year-end, book-balancing approach is consistent with that focus. By contrast, if Congress had intended clause (ii) to afford a provider a right to insist upon individualized *exceptions* to regulatory standards (including cost limits) on equitable grounds, as petitioners contend, there would have been no reason to give it only retrospective effect.

Second, clause (ii) refers to "corrective" adjustments. That reference strongly suggests that clause (ii) is modest in scope and contemplates only the elimination of inaccuracies in the application of reimbursement methods prescribed by regulation—*e.g.*, where year-end data concerning actual costs show that the estimates on which interim payments were based were erroneous—not the revisiting of substantive reimbursement policies. By contrast, petitioners' interpretation pays no heed to the term "corrective." Petitioners' approach would necessitate a fresh inquiry into substantive reimbursement issues at

the end of each year, and would require an adjustment even where the reimbursement methods prescribed by regulation had been properly applied on the basis of accurate data.

Third, clause (ii) focuses on whether the "aggregate" reimbursement produced by *all* "methods" employed in determining reasonable costs for the provider for the fiscal period was either inadequate or excessive. The quoted terms indicate that clause (ii) takes the various "methods" prescribed by the Secretary as a given, and is concerned only with the bottom-line issue addressed by the Secretary's book-balancing regulations. Petitioner's approach, by contrast, would disaggregate the inquiry and permit the provider to question and seek a departure from each and every "method" (validly prescribed by the Secretary) that was utilized in calculating the provider's reasonable costs. The Secretary's implementation of clause (ii) through the book-balancing regulations also comports with 42 U.S.C. 1395g, which provides for interim, pre-audit payments to providers based on estimated costs. That Section necessarily contemplates some mechanism under other provisions of the Act, to reconcile those interim payments with the provider's actual costs at the end of the year. Clause (ii) provides that mechanism. Petitioner's approach ignores this relationship between clause (ii) and 42 U.S.C. 1395g.

Fourth, clause (ii) requires a corrective adjustment only where the aggregate reimbursement proves to be either "inadequate" or "excessive." But inadequate or excessive compared to what? The answer must be: inadequate or excessive compared to the statutory standard of reasonableness in 42 U.S.C. 1395x(v)(1)(A) itself. The content of that standard is found in the various "methods" including cost limits) that are contained in the regulations prescribed by the Secretary for determining reasonable costs. Petitioners contend (Pet. Br. 13, 21-22) that clause (ii) requires reimbursement of *all* costs they may show to be "reasonable" under some un-

specified standard, regardless of the "methods" established by the Secretary's regulations. This contention ignores the third sentence of 42 U.S.C. 1395x(v)(1)(A), which not only authorizes the Secretary to establish cost limits, but also provides that they shall "be recognized as reasonable." It also ignores the fact that clause (ii) only requires the regulations to provide for those retroactive corrective adjustments that are "suitable." The Secretary may properly determine that it is not "suitable" to provide for adjustments to accommodate a provider's disagreement with validly promulgated cost limits.

Finally, clause (ii) does not authorize an *ad hoc* disregard of the Secretary's reimbursement regulations, as petitioners would have it, but rather prescribes one feature that those regulations must contain—a provision for "retroactive corrective adjustments." Those "retroactive adjustments" must be made against the standard of the cost limits themselves, since those limits are also contained in the regulations and represent, by definition, "reasonable costs."

At the very least, the Secretary's position that clause (ii) does not require the sort of adjustment petitioners seek is based on a permissible construction of clause (ii) and of 42 U.S.C. 1395x(v)(1)(A) as a whole. It therefore should, under *Chevron*, be sustained. Indeed, the fact that clause (ii) is to be implemented through regulations, as an integral part of the complex regulatory scheme giving content to the statutory "reasonable cost" standard, confirms that Congress has delegated that implementation to the Secretary in a manner that commands particular deference by the courts. See, *e.g.*, *Bowen* v. *Yuckert*, 482 U.S. 137, 145 (1987); *Batterton* v. *Francis*, 432 U.S. 416, 424-426 (1977).

B. The History Of Clause (ii) And The 1972 Amendments Authorizing Cost Limits Both Support The Secretary's Interpretation Of Clause (ii) In This Case

The meaning of clause (ii) evident from its language and the text of 42 U.S.C. 1395x(v)(1)(A) as a whole is confirmed by its history and contemporaneous interpretation. This case specifically involves the interaction of clause (ii) and the regulatory cost limits promulgated by the Secretary under explicit authority granted in the immediately preceding sentence of 42 U.S.C. 1395x(v)(1)(A). Clause (ii) has been part of the Medicare program since its inception in 1965, but the authorization for cost limits was added by 1972 amendments to the Medicare statute. Both the original enactment and subsequent amendments support the court of appeals' rejection of petitioner's reliance on clause (ii) to avoid the cost limits.

1. *Clause (ii) as Originally Enacted*

a. The Medicare program was established by the Social Security Amendments of 1965, Pub. L. No. 89-97, § 102, 79 Stat. 291, which added a new Title XVIII, comprising Sections 1801-1875, to the Social Security Act. Section 1814(b) of the new title, 79 Stat. 296 (codified at 42 U.S.C. 1395f(b)), provided that hospitals and other health care providers were to be reimbursed (subject to certain coinsurance and deductible amounts) for the "reasonable cost" of the services they provided. Section 1815, 79 Stat. 297 (codified at 42 U.S.C. 1395g), directed the Secretary to "periodically determine the amount which should be paid * * * to each provider of services with respect to the services furnished by it," and to pay "the amounts so determined" to the provider no less often than monthly. Section 1814(b) specified that the "reasonable cost"—*i.e.*, the amount to be paid to the provider—was to be "determined" under Section 1861(v), 79 Stat. 322-

323 (codified at 42 U.S.C. 1395x(v)). That section, in turn, provided for "regulations establishing the method or methods to be used, and the items to be included, in determining such costs." Those regulations could permissibly prescribe any of a variety of cost determination techniques,[10] but were required by clause (i) to take into account indirect as well as direct costs and by clause (ii) to "provide for the making of suitable retroactive corrective adjustments."[11] The legislative history of the latter clause furnishes no reason to depart from the interpretation required by its text, discussed at pages 15-18, *supra*. The Senate and House reports simply repeat the language of clause (ii), without further explanation. S. Rep. No. 404, 89th Cong., 1st Sess. Pt. I, at 186 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 168-169 (1965).

b. The interpretation of clause (ii) required by its text was reflected in the regulations implementing the cost provisions of Title XVIII that were issued in final form in November, 1966, little more than a year after enactment of the Medicare program. 31 Fed. Reg. 14,808. The regulations restated the "reasonable cost" principle, 20 C.F.R. 405.401(a) (1967), and implemented statements in the congressional committee reports that the Act contemplated reimbursement for a provider's "actual costs, however widely they may vary from one institution to another," subject to limitation only where a particular provider's costs were found to be "substantially out of line" with those of similar institutions. 20 C.F.R. 405.451(c) (1967); see S. Rep. No. 404, *supra*, at 35-36; H.R. Rep. No. 213, *supra*, at 31-32.

[10] "Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs." Pub. L. No. 89-97, § 102, 79 Stat. 322-323 (§ 1861(v)(1)).

[11] The denomination of the clause—"(B)" in the original Act—was changed to "(ii)" in 1972, when Section 1861(v) was amended and reorganized into subsections (A)-(E). See Pub. L. No. 92-603, §§ 227(c), 249(b), 86 Stat. 1405, 1426.

The original regulations also implemented the accounting and payment provisions of the Act. The introductory regulation noted as a basic principle that reimbursement was to be furnished on the basis of actual and current (rather than historical or fixed) costs. 20 C.F.R. 405.402(a) (1967). Thus, "the methods of reimbursement should result in current payments," so as not to force institutions to advance funds well before receiving payment, and "there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively." 20 C.F.R. 405.402(b)(1)-(2). Section 405.405(c) of the regulations then described generally the integrated process adopted to achieve these dual ends:

> Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. * * * The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

The subsequent, more detailed sections of the regulations reiterated and elaborated upon this basic scheme. Section 405.451(b)(1), defining "reasonable cost," noted:

> These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year * * * and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

Finally, Section 405.454, which contained the most detailed description of the mechanics of the payment system, provided in subsections (c) through (e) for interim payments based on estimates of costs incurred, with adjustments in light of actual experience. Subsection (f) then provided for initial and final retroactive adjustments to be made at the end of the reporting period (the first before the audit and the latter after), in order to balance the total of the interim payments made during the period with the aggregate reimbursement ultimately determined to be due to the provider under the regulations governing cost allowance and apportionment.

As this Court has noted, the language of Sections 405.451 and 450.454 makes clear that they were intended specifically to implement clause (ii). *Georgetown University Hospital*, 488 U.S. at 211-212 n.2. Together with the other provisions of the regulations outlined above, they demonstrate that clause (ii) was understood to impose an important but limited requirement on the Medicare program's system of reimbursement accounting: that whatever *interim* cost estimates might be used to satisfy the statutory command to pay providers no less often than monthly, the regulations must ensure that each provider ultimately received no more or less than the amount that would compensate it fully for the allowable costs—determined as provided elsewhere in the regulations—it actually incurred in providing care to covered patients during a given period. No other role (including that posited by petitioners) was assigned to clause (ii) by the Secretary. As the contemporaneous interpretation of a complex regulatory statute by the agency charged with its implementation, this construction of the Act is, of course, entitled to great weight. *E.I. DuPont de Nemours & Co.* v. *Collins*, 432 U.S. 46, 55 (1977) (quoting *FTC* v. *Mandel Bros.*, 359 U.S. 385, 391 (1959)); see also *Davis* v. *United States*, 495 U.S. 472, 484 (1990); *Red Lion*

Broadcasting Co. v. *FCC*, 395 U.S. 367, 381 (1969); *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965).

It also is significant that this interpretation was brought to Congress's attention at the outset of the program. In May, 1966, the Senate Finance Committee—the committee directly responsible for the legislation passed by the same Congress only a few months before—held working hearings to consider in detail several issues raised by the Secretary's draft reimbursement regulations. See generally *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. (1966).[12] Congressional and Executive Branch participants during these hearings referred repeatedly to the retroactive adjustment provision of the statute as a year-end, book-balancing mechanism. See *id.* at 66 (HEW General Counsel Willcox) ("The law specifically provides for retroactive adjustment at the end of an accounting period" to correct over-reimbursements); *id.* at 67 (Social Security Commissioner Ball); *id.* at 96 (Chief Counsel, Senate Finance Committee) (the legislation "probably * * * permit[s] an estimate" of costs, "provided that adjustments, retroactive adjustments, which are authorized by the statute, would recapture any excess payments" and make up any underpayments); *id.* at 109 (Senator Anderson) ("There is a provision in the bill, I believe, that lets you go back at the end of a year and refigure your bills."). Given the

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[12] These issues included whether depreciation on assets paid for with public funds should be allowed as a cost, whether the statute authorized the Secretary to pay more than the actual costs of care, the propriety of including return on investment as a cost for proprietary but not for non-profit facilities, and the legality and desirability of paying participating providers one month's estimated reimbursement in advance. See *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 3 (1966).

specific mention of "retroactive" adjustments, we think it clear that these statements refer to clause (ii), and support the Secretary's construction of its function.[13]

Finally, in his first annual report to Congress on the operation of the Medicare system, the Secretary summarized the reimbursement procedure in similar terms, again invoking clause (ii)'s language of "retroactive adjustment":

> Under procedures in effect from the start of program operations, interim payments approximating a provider's actual costs are made, at least monthly, and in most cases, weekly, by intermediaries as bills for covered services are submitted. Intermediaries make appropriate adjustments in the interim rate of payment and lump-sum payments to bring past payments in line with costs during the reporting period. *A retroactive adjustment based on the actual costs is made at the end of the provider's reporting period.*

1st Annual Report On Medicare, H.R. Doc. No. 331, 90th Cong., 2d Sess. 41 (1968) (emphasis added); see also *id.* at 9.

Thus, from the beginning of the Medicare program, the function of clause (ii) was to authorize an annual reconciliation between the aggregate amount of the interim payments made to providers during the year and the aggregate amount actually found to be owing under the applicable methods prescribed for determining reasonable costs. There was no suggestion of the far different and more expansive role petitioners urge, under which clause (ii) would furnish independent authority for a provider (or the Secretary) to alter or evade the substantive determination of reasonable costs under governing regulations.

c. Petitioners do not dispute that the regulations discussed above provided for no more than year-end book balancing; they claim instead that the entire authority for such regulations is properly found in 42 U.S.C. 1395g, rather than in clause (ii) of 42 U.S.C. 1395x(v)(1)(A). See Pet. Br. 19-21, 23. Petitioners are wrong. To begin with, their argument ignores the fact that, whatever petitioners may now assert, those charged with the initial implementation of the Medicare program considered clause (ii) to be the statutory basis for the retroactive annual adjustment mechanism they so thoroughly embedded in the regulatory scheme. See *Georgetown Uni-*

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[13] During the Finance Committee hearings the following colloquy occurred (at 119-120) between Senator Anderson and Social Security Commissioner Ball, concerning the operation of the provider reimbursement process (the specific question being the propriety of a proposed 2% allowance for costs not specifically identified):

> Senator Anderson: What does the law require?
>
> Mr. Ball: That we pay cost.
>
> Senator Anderson: If you find out you haven't paid cost—you have to pay it then. Why don't you find out about it?
>
> Mr. Ball: I don't think that the retroactive provision contemplates going back over the year and changing the principles. I think what is contemplated is that you pay first on the basis of * * * estimates * * *. [Y]ou make an estimate at the beginning of the year on the basis of these principles. Then at the end of the year you settle up, on the basis of the principles put out. It would hardly seem reasonable at the end of the year, after hospitals had entered into an agreement with you on the basis of certain principles, to shift all the principles for retroactive settlement in terms of how you compute a cost. I don't think that was contemplated at all.
>
> Senator Anderson: Well, why cannot a hospital find out what its costs are at the end of the first year?
>
> Mr. Ball: Well, the question of what are the costs is a matter of what principes are agreed upon as the basis for the cost determination.

Both Congress and the Executive understood from the outset of the Medicare program that the function of clause (ii) was to authorize a "settl[ing] up" at "the end of the year," based on the appropriate "principles" of reimbursement, whatever those "principles"—defined elsewhere in the law and regulations—might be.

versity Hospital, 488 U.S. at 211 n.2.[14] Petitioners cite no evidence that anyone at the time thought differently. Their argument (Pet. Br. 20-21 n.18) that such regulations should now be thought to rest exclusively on 42 U.S.C. 1395g comes far too late in the history of the program.

In any event, there is no merit to petitioner's contention that 42 U.S.C. 1395g fully addressed the subject of annual book-balancing, so that the Secretary's interpretation of clause (ii) would render it redundant. Then as now, 42 U.S.C. 1395g provided for periodic interim payments "prior to audit or settlement," including "necessary adjustments on account of previously made overpayments or underpayments." 79 Stat. 297; 42 U.S.C. 1395g(a). That language is fully reflected in both the original and the current reasonable cost regulations, which repeatedly provide for adjustments to the amount of the numerous interim payments made *during the course of the fiscal year*, based on estimated costs. See 20 C.F.R. 405.405(d); 405.454(c)(4), (d)(2), (e), (f)(1) (1967) (now codified at 42 C.F.R. 413.64(c)(4), (d)(2), (e), (f)(1)).[15] It contrasts with the "retroactive corrective adjustments"

[14] Indeed, the statutory authority cited by the Secretary for the initial cost reimbursement regulations as a whole included only Social Security Act Section 1814(b) (the general requirement for reasonable cost reimbursement) *and Section 1861(v)* (the reasonable cost provision that includes clause (ii))—in addition to the general rulemaking provisions in Sections 1102 and 1871 of the Act, 42 U.S.C. 1302 and 1395hh. See 31 Fed. Reg. 14,808 (1966). There was no mention of Section 1815 of the Act, 42 U.S.C. 1395g.

[15] For example, Section 405.454(e) of the original regulations, now 42 C.F.R. 413.64(e), provided that the "interim rate of payment may be adjusted by the intermediary during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate."

language taken from clause (ii), which also occurs repeatedly in the regulations, and which refers to a comparison of the aggregate reimbursement produced by the interim payments and the aggregate post-audit reimbursement ultimately determined to be due, producing one final *year-end* adjustment. See, *e.g.*, 20 C.F.R. 405.451(b)(1), 405.454(f) (1967) (now codified at 42 C.F.R. 413.9(b)(1)). The different statutory provisions thus speak to different phases of the reimbursement process; neither is "mere surplusage." See Pet. Br. 23.[16]

[16] It is possible that if clause (ii) had not been enacted, the authority for some similar year-end mechanism might have been inferred under the Act as a whole, including 42 U.S.C. 1395g. But the fact that Congress made clear what might have been inferred hardly renders the clarification "surplusage."

Furthermore, the interim and annual adjustment provisions serve different legislative purposes, which explains their different statutory placement. As the initial regulations explained, the interim payments prescribed by 42 U.S.C. 1395g are intended to protect participating providers' liquidity. See 20 C.F.R. 405.402(b)(1) (1967). In order to serve that goal without unduly burdening the fisc or subsidizing providers' non-program costs, it made sense to provide that whatever estimates were used for interim payments should be adjusted periodically to ensure that they were as accurate as possible. See 20 C.F.R. 405.454(b). It was also a guiding principle of the Act and regulations, however, that payment would be made "on the basis of current costs * * * rather than costs of a past period or a fixed negotiated rate." 20 C.F.R. 405.402(a). The year-end "retroactive adjustment" was thought of primarily as a means to ensure that reimbursed costs ultimately would exactly equal the provider's actual costs (insofar as they were "reasonable"). See *id.* § 405.402(b)(2). See also S. Rep. No. 404, *supra*, at 37 ("[i]n paying reasonable costs it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred"). Because Congress thought of the year-end retroactive "corrective" adjustments to aggregate reimbursement primarily in terms of maintaining the integrity of the reasonable cost reimbursement principle, it is not surprising that the clause specifically requiring such adjustments was included in the statutory provision that dealt most specifically with that principle (42 U.S.C. 1395x(v)(1)(A)), not in the section dealing with interim payments of estimated and unaudited costs (42 U.S.C. 1395g).

2. *The 1972 Cost Limit Amendments*

The early history of clause (ii), just discussed, demonstrates that while that clause serves an important function in implementing the general principle of reimbursing providers for their actual (as opposed to estimated) reasonable costs, it does not speak to the question of what costs are to be recognized as "reasonable." That question must be answered instead by reference to principles and methods set forth elsewhere, including in the remainder of 42 U.S.C. 1395x(v)(1)(A) and the regulations thereunder. Congress itself has from time to time altered those principles, or directed changes in the applicable methods. It did so for the first time in 1972, when it adopted the cost limit principle at issue in this case. Those amendments further undermine petitioners' reliance on clause (ii) to avoid the cost limits.

a. The original Medicare Act had contemplated—and the initial regulations had confirmed—that providers' reimbursable costs might vary widely, and that, within broad limits, each provider should be compensated for its "actual costs of providing quality care." 20 C.F.R. 405.451(c) (1967). See, *e.g.*, S. Rep. No. 404, *supra*, at 35-36. By 1971, however, Congress had become concerned that "reasonable cost" reimbursement under the 1965 Act essentially permitted providers to recover whatever costs they might incur, even when those costs resulted from inefficiency or inappropriate expenditures. See H.R. Rep. No. 231, *supra*, at 82-85; S. Rep. No. 1230, *supra*, at 188-189.[17] As the Committee reports concluded,

[17] Although under the 1965 Act the Secretary had "authority to disallow incurred costs that are not reasonable," Congress recognized that this system presented problems for both the Secretary and providers. See H.R. Rep. No. 231, *supra*, at 83. Because the Secretary could disallow costs only on a case-by-case basis, it was often difficult to establish that a particular provider's costs were out of line. On the other hand, disallowance of costs already incurred by a provider "create[d] financial uncertainty for the provider" since it "ha[d] no way of knowing until sometime after it incur[red] expenses" whether they would be comparable to those of other providers in the same period and, therefore, "allowable" under the Secretary's regulations. *Ibid.*

> Health care institutions, like other entities in our economy, should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

H.R. Rep. No. 231, *supra*, at 83; S. Rep. No. 1230, *supra*, at 187.[18]

In 1972, therefore, Congress toughened the governing principles of cost reimbursement. The new law added to the first sentence of 42 U.S.C. 1395x(v)(1)(A) a new statutory definition of "reasonable cost": "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." Pub. L. No. 92-603, § 223(a), 86 Stat. 1393. It then authorized the Secretary to promulgate regulations establishing "limits on the * * * incurred

[18] Congress's concern with controlling improper costs disposes of petitioners' argument (Pet. Br. 16) that the "inevitable consequence" of the Secretary's position will be to shift part of the cost of treating Medicare patients to non-Medicare patients, in violation of clause (i) of 42 U.S.C. 1395x(v)(1)(A). Because a provider could always be expected to claim that it would be "forced" to shift costs in excess of the Secretary's limits to non-Medicare patients, petitioners' argument would vitiate the cost limit concept. But Congress clearly did not intend the Medicare program to be held to account for a provider's decision to foist onto its other patients costs that Congress and the Secretary had concluded were not otherwise reimbursable.

costs * * * to be recognized as reasonable" for Medicare purposes, "based on estimates of the costs necessary in the efficient delivery of needed health services" to covered individuals. *Ibid.* The new limits were expected to be imposed prospectively, so that providers "would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable." S. Rep. No. 92-1230, *supra*, at 188.

As explained above, the Secretary first published cost limit regulations in 1974, and has issued a series of implementing announcements annually since that time.[19] See pages 4-5, *supra*. The regulations establish the basic principle that costs in excess of the applicable limits are not reimbursable under Medicare. See 20 C.F.R. 405.460(a) (1975); 42 C.F.R. 413.30(a). The regulations also provide, however, for limited exceptions to and exemptions from the limits in particular situations in which reasonable costs might be expected or shown to exceed the limits. See 20 C.F.R. 405.460(f) (1975), redesignated as 42 C.F.R. 413.30(e) and (f). Since 1974, the Secretary has acted to expand these regulatory exceptions in the light of program experience. See, *e.g.*, 44 Fed. Reg. 31,802 (1979).

Petitioners concede (Pet. Br. 22 n.19) that they do not qualify for any regulatory exception to or exemption from the applicable cost limits. They contend instead that clause (ii) confers on them a substantive right to individual, *ad hoc* adjudications of their claims that certain of their costs were "reasonable," and hence reimbursable without regard to any other standard. That contention is untenable.

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[19] The cost limits promulgated by the Secretary have never covered all costs reimbursable under the general "reasonable cost" standard. The first set of limits, for example, applied only to hospital inpatient general routine service costs. 39 Fed. Reg. 20,168-20,169 (1974). Thus, in periods when costs limits applied, most providers would be expected to have some costs which were subject to limitation and other costs subject only to the original "substantially out of line" standard of 20 C.F.R. 405.451(c)(2) (1967) (now codified at 42 C.F.R. 413.9(c)(2)).

Petitioners argue (Pet. Br. 17) that the 1972 amendments "left clause (ii) intact." We agree. There is nothing to suggest that the 1972 Congress intended to change the annual book-balancing system established by the regulations under clause (ii). Indeed, the fact that Congress declined to alter the text of clause (ii)—even though it substantially revised 42 U.S.C. 1395x(v)(1)(A) in other respects—strongly supports the soundness of the Secretary's implementation of clause (ii) through the book-balancing regulations that were in effect from 1967 onwards.

It does not follow, however, as petitioners contend (Pet. Br. 16-17), that the 1972 amendments did not change the principles of reasonable cost reimbursement. On the contrary, the natural reading of the amendments (and their legislative history) is that they did exactly what the term "cost limits" would imply: they authorized the "establishment of limits" on the costs that would be "recognized as reasonable" for Medicare purposes. 86 Stat. 1393. It is that straightforward change that petitioners seek to avoid through their misinterpretation of clause (ii).

b. Petitioners stress selected phrases from the legislative history of the 1972 amendments, including that the limits would be imposed on a "presumptive" basis and that providers would have "the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." S. Rep. No. 1230, *supra*, at 188-189. Those comments suggest noting more than an intention that the Secretary should make some provision for exemptions or exceptions from the cost limits in appro-

priate cases.[20] This the Secretary has done. See 42 C.F.R. 413.30(c)-(f) ("Provider requests regarding applicability of cost limits"—"Reclassification," "Exemptions" and "Exceptions").

In fact, petitioners are merely trying to press clause (ii) into service to fight again a battle that they have already lost. In the courts below, petitioners directly challenged the reasonableness of the cost limits applicable to them, and sought an order declaring those limits invalid. Pet. App. 14a-15a; J.A. 13-15, 18-19. The court of appeals rejected petitioners' arguments, concluding that "[t]here is nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a. That ruling was clearly correct,[21] and in any event petitioners have not challenged it in this Court. Instead, they now seek to attack the cost limits in a different way, by claiming that although they are

[20] The Committee reports themselves suggested one such exemption, for sole community hospitals. See S. Rep. No. 1230, *supra*, at 188; 42 C.F.R. 413.30(e)(1).

[21] The courts have recognized that Medicare regulation "cannot be accomplished on a hospital-by-hospital basis," and that the Secretary "must make generalizations in achieving [the] overall regulatory goals" of the Medicare program. *City of Austin* v. *Heckler*, 753 F.2d 1316, 1317-1318 (5th Cir. 1985). Accord, *Fairfax Hosp. Ass'n, Inc.* v. *Califano*, 585 F.2d 602, 606 (4th Cir. 1978). The fact that the Secretary's cost limit regulations provide relief for only "some" providers, and not for petitioners (see Pet. Br. 22), hardly impugns the rationality of the Medicare reimbursement system. The Secretary was certainly justified in not accounting for part-time employees in his wage index, given the paucity of accurate information available at the time. Indeed, when Congress directed the Secretary to develop the necessary data, it explicitly made the revised wage index applicable only to costs for patients discharged on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156 (1986). Similarly, the Secretary's use of location in or outside an SMSA to classify hospitals for reimbursement purposes may be imperfect, but is certainly rational.

valid in general, clause (ii) allows them to be circumvented in particular. But even if clause (ii) might have been given a more expansive role when cost limits did not apply, the Secretary surely could determine after 1972 that it would not be "suitable" to make "retroactive corrective adjustments" under that clause where the only rationale for doing so would be to permit a provider to avoid the cost limits that were validly promulgated pursuant to the 1972 amendments to 42 U.S.C. 1395x(v)(1)(A).[22]

C. Petitioners' Reliance On Clause (ii) In This Case Is Foreclosed By This Court's Decision In *Bowen* v. *Georgetown University Hospital*

The result that petitioners seek in this case is also inconsistent with this Court's construction of clause (ii) and the cost limits in *Bowen* v. *Georgetown University Hospital*, *supra*. In *Georgetown* the Secretary, relying on expansive readings of clause (ii) by some lower courts in cases brought by providers, see pp. 38-39, *infra*, argued that the clause provided statutory authority for the promulgation in 1984 of regulations applicable retroactively as of July 1, 1981. See 488 U.S. at 209. The Court, however, rejected this interpretation. Indeed, the Court cited the book-balancing regulations discussed above, 20 C.F.R. 405.451(b)(1), 405.454(a) and (f) (1967), as indicative of the Secretary's prior—and, implicitly, correct—implementation of clause (ii). 488 U.S. at 211-212 & n.2; see also *id.* at 212-213.

The Court commented in *Georgetown* that the statutory language "suggests that clause (ii), rather than permitting modifications to the cost-method rules in their

[22] It is of course axiomatic that revised statutory provisions prevail over prior law as "the latest declaration of the legislative will." N. Singer, *Sutherland Statutory Construction* §§ 22.34 (at 293), 51.02 (at 121) (1985). See also, *e.g.*, *Clark* v. *Uebersee Finanz-Korporation*, 332 U.S. 480, 489 (1947).

general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers." 488 U.S. at 210. Moreover, the Court observed that the cost limit rules are one of the "methods of determining costs" referred to in the language of clause (ii), and that "nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods." *Id.* at 211 (emphasis in original). Finally, the Court expressed its view that "clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." *Id.* at 209.

The Court's observations in *Georgetown* are fully consistent with the "narrow view," 488 U.S. at 212-213, which the Secretary originally espoused and to which he has returned in light of this Court's decision in that case. Clause (ii) speaks of corrective adjustments to the aggregate reimbursement produced by the "methods of determining costs" prescribed under 42 U.S.C. 1395x (v)(1)(A)—*i.e.*, standards of allowability, methods of apportionment, and cost limits. These methods are first applied in the process of estimating the appropriate interim reimbursement rates required by 42 U.S.C. 1395g and the regulations. See, *e.g.*, 42 C.F.R. 413.60, 413.64. Cf. *id.* § 413.5(b)(1) (emphasis added) (stating that "the *methods of reimbursement* should result in current payment"—under the interim payment system—to preserve provider liquidity). The interim application of the cost determination methods, and the payments calculated thereunder, will always be based on estimates. Thus, in practice, the "aggregate reimbursement produced" by applying the prescribed "computation methods"—*i.e.*, the total of all of the interim payments made during the

year—will always require a "suitable retroactive corrective adjustment" of some sort. Clause (ii) thus speaks only to correcting the results of the necessary inaccuracies involved in the interim cost estimation process. It does not authorize a *post hoc* revision of the substantive methods applied both in generating those estimates and in reconciling the provider's aggregate provisional reimbursement with the amount finally determined, after audit, to be due.

Petitioners nevertheless rely on *Georgetown*. Pet. Br. 14-15, 20-21 n.18, 27-28. They argue that the Court there drew a distinction between retroactive rulemaking and "case-by-case adjustments," invalidating only the former.[23] Petitioners argue that they seek only a "case-by-case" retroactive change in the Secretary's methods where those methods "produce inadequate reimbursement of [their] reasonable costs." Pet. Br. 15; see also *id.* at 22, 27-28.[24] But petitioners' approach would permit providers—or the Secretary—to seek retroactive modifications having the same practical effect as the retroactive rulemaking barred by this Court in *Georgetown*.

The district judge in *Mt. Diablo Hospital*, *supra*, recognized this consequence, noting that clause (ii) is a "two way street" in that it "applies to adjustments where the

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[23] We agree that clause (ii) requires "case-by-case adjustments." But they must be "adjustments" to the provider's "aggregate reimbursement" within the framework of the Secretary's reimbursement regulations—not, as petitioners seek here, *ad hoc* adjustments designed to circumvent the Secretary's lawful regulations.

[24] Petitioners ask this Court to remand their case to the Provider Reimbursement Review Board for "the opportunity to demonstrate that their costs in excess of the cost limits are reasonable." Pet. Br. 29. In the court of appeals, they argued for an across-the-board adjustment to their wage index, regardless of their actual costs or percentage of part-time employees. Pet. C.A. Rep. Br. 16 n.8; Gov't C.A. Reply Br. 6. The court of appeals recognized that this amounted to a request for a "retroactive rule chang[e]," and rejected the argument. Pet. App. 13a.

aggregate reimbursement is shown to be '. . . either inadequate or excessive.'" *Mt. Diablo Hospital Medical Center* v. *Sullivan*, No. C-89-2714-DLJ (N.D. Cal. May 24, 1990), slip op. 13, rev'd, 963 F.2d 1175 (9th Cir. 1992), petition for cert. pending, No. 92-720. As the judge explained,

> Under [the provider's] interpretation of clause (ii), the Secretary in the *Georgetown Univ. Hospital* scenario could have determined the claimed expenses to be unreasonable and retroactively adjusted such "excessive" payouts on a hospital-by-hospital basis, even after the Supreme Court held that the Secretary was without rule-making authority under clause (ii). Such a result could not have been within the contemplation of the Supreme Court. Case-by-case retroactive adjudication ultimately has the same practical effect as across-the-board retroactive rule-making.

Slip op. 13-14. The court of appeals in this case agreed, stating that petitioners' request for a court order requiring the Secretary "to retroactively adjust cost limits for the number of part-time workers * * * amount[s] to a retroactive change in the *methods* that, after *Georgetown*, is invalid." Pet. App. 13a. See also *Hennepin County* v. *Sullivan*, 883 F.2d 85, 86-87, 92-93 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990) (clause (ii) "is not a vehicle through which Medicare providers may get a 'second bite at the applie' on claims for exceptions to limitations on reimbursable costs"); *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990).

Neither *Georgetown's* holding nor its discussion of clause (ii) can be reconciled with petitioners' position in this case. However they may characterize their argument, petitioners at bottom are attempting to use clause (ii) to avoid the application to them of otherwise valid cost limits. Yet *Georgetown* specifically states that the clause does not permit changes in the methods, including cost limits, used to compute reimbursable cost. 488 U.S. at 211.

Moreover, although the Court in *Georgetown* stressed the individual, case-by-case nature of whatever adjustment is required by clause (ii)—consistent with the provider-specific details of a yearly reconciliation between estimated payments and actual costs—the logic of petitioner's position would allow *any* similarly situated provider to demand equal treatment, thus accomplishing in effect a wholesale revision of the cost limit rules. See Pet. Br. 22, 27-28.[25]

D. The Secretary's Interpretation Of Clause (ii), Which Is Consistent Both With *Georgetown* And With The Original Construction Of The Statute, Is Entitled To Deference From This Court

Petitioners argue (Br. 23-25) that any claim of deference to the Secretary's construction of the Medicare Act is undermined by variations in the government's positions over the years. While the Secretary's position on the

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[25] Petitioners' reliance (Br. 25-27) on *Bethesda Hospital Ass'n* v. *Bowen*, 485 U.S. 399 (1988) as a basis for disregarding the Secretary's cost limit regulations is similarly unavailing. That case involved a *procedural* question of exhaustion of administrative remedies—namely, whether a provider is required to raise a reimbursement issue before its fiscal intermediary in order to preserve that claim for review by the PRRB. Relying on the text of a statutory provision not at issue here, 42 U.S.C. 1395*oo*, the Court held that the Act imposes no such exhaustion requirement. 485 U.S. at 403-405. Nothing in the Court's decision suggests that the PRRB may ignore *substantive* limitations in the Secretary's regulations, including those imposing cost limits. Indeed, the Court observed that the PRRB cannot "declare regulations invalid" (485 U.S. at 406 (citing 42 U.S.C. 1395*oo*(f)(1)) and that the providers acknowledged that the PRRB lacked "authority" to disregard the Secretary's regulations and to give them "the relief they sought." Furthermore, the instances cited by petitioners where "the [PRRB] has actually served as the mechanism for clause (ii) adjustments" in disregard of the Secretary's regulations have all occurred in situations where the courts have specifically ordered such a result. See cases cited at Pet. Br. 27.

meaning of clause (ii) did in fact vary at times between the inception of the program and 1988, positions differing from that reflected in the original Medicare regulations stemmed largely from the disarray that prevailed for some time among the lower courts on this issue. Furthermore, since this Court's construction of clause (ii) in *Georgetown*, the Secretary has returned to the "book-balancing" interpretation reflected both in that decision and in the initial Medicare regulations.

The federal courts, like the Secretary, initially adopted the "book-balancing" interpretation. See, *e.g.*, *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 376 F. Supp. 1099, 1127-1129 (S.D. Fla. 1974) (analyzing the relationship between clause (ii) and 42 U.S.C. 1395g(a)), aff'd, 517 F.2d 329, 335 (5th Cir. 1975). In the mid-1970's, however, the Second Circuit and the United States Court of Claims rejected the Secretary's arguments that his "book-balancing" regulations fully implemented clause (ii), finding instead that the clause required the Secretary to retroactively change his reimbursement methods "wherever a cost method produce[d] an inaccurate reimbursement." *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351-352 & n.11 (Ct. Cl. 1976) (retroactive application of subsequently collected data); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663, 669-671 (2d Cir. 1973) (retroactive application of subsequently issued Medicare ruling to earlier cost years).

Whatever type of adjustments clause (ii) authorizes apply to "excessive" as well as to "inadequate" prior payments. In light of *Whitecliff* and *Kingsbrook*, therefore, the Secretary in the late 1970's argued for a more substantive role for clause (ii), principally to recoup through "retroactive corrective adjustments" accelerated depreciation that had been claimed in earlier years by providers that subsequently left the Medicare program.

Fairfax Nursing Center v. *Califano*, 590 F.2d 1297 (4th Cir. 1979); *Springdale Convalescent Center* v. *Mathews*, 545 F.2d 943, 954 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital, Inc.* v. *Weinberger*, 543 F.2d 703 (9th Cir. 1976), vacated on other grounds, 430 U.S. 952 (1977); *Humana of South Carolina* v. *Califano*, 590 F.2d 1070, 1079 n.66 (D.C. Cir. 1978).[28] But see *Daughters of Miriam Center for the Aged* v. *Mathews*, 590 F.2d 1250 (3d Cir. 1978) (rejecting application of accelerated depreciation regulations to pre-issuance conduct). Further, in the early 1980's, when the cost limit issues present in this case began to appear in litigation, several lower courts initially adopted a similar reading of clause (ii). *Medical Center Hosp.* v. *Bowen*, 839 F.2d 1504 (11th Cir 1988); *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (8th Cir. 1987); *Regents of the Univ. of California* v. *Heckler*, 771 F.2d 1182 (9th Cir. 1985).

As is obvious from the discussion above, however, any reading of clause (ii) that would permit retroactive

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[28] *Mercy Community Hosp.* v. *Blue Cross Association/Blue Cross of Florida, Inc.*, [1983-1 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 32,316, at 9542 (Nov. 4, 1982), cited by petitioners, Pet. Br. 24, is a similar case.

Humana of Illinois, Inc. v. *Heckler*, No. 84-1727 (7th Cir. Apr. 18, 1985), consolidated with *St. James Hospital* v. *Heckler*, 760 F.2d 1460, 1473 n.9 (7th Cir.), cert. denied, 474 U.S. 902 (1985), is also similar. The brief filed by the Secretary in that case and cited by petitioners here (Pet. Br. 13-14 n.13, 24) argued that the regulations on reopening of determinations and decisions, 42 C.F.R. 405.1885(a) (1984), were authorized by clause (ii). Particularly in light of the intervening decision in *Georgetown*, the Secretary now believes that the reopening regulations are properly premised not on clause (ii), but on the Secretary's general rulemaking authority. See 42 U.S.C. 1395hh. Lower courts have accepted that position without comment. See *Memorial Hospital* v. *Sullivan*, 779 F. Supp. 1406, 1409 (D.D.C. 1991); *Albert Einstein Medical Center* v. *Sullivan*, Civil No. 91-6119 (E.D. Pa. Nov. 24, 1992), slip op. 12.

changes in the Secretary's methods of reimbursement whenever they resulted in "inadequate" or "excessive" payments was rejected by this Court in *Georgetown*. Indeed, although the issue was not directly presented, *Georgetown* appeared to adopt the Secretary's original "book-balancing" construction of clause (ii). See 488 U.S. at 210-212 & n.2, 213.

Since *Georgetown*, the Secretary has returned to this original construction. His position here takes into account this Court's authoritative construction of clause (ii), see *Lechmere, Inc.* v. *NLRB*, 112 S. Ct. 841, 847-848 (1992), as well as his interpretation of other relevant statutory provisions and his accumulated experience in administering the Medicare program. See Pet. App. 10a-14a; *Hennepin County* v. *Sullivan*, 883 F.2d at 86-87, 92-93; *Sierra Medical Center* v. *Sullivan*, 902 F.2d at 393.[27] The

[27] *Sutter Community Hospitals* v. *Heckler*, No. S-82-204 (RAR) (E.D. Cal. Feb. 16, 1984), aff'd, 765 F.2d 150 (9th Cir. 1985) (Table), cited by petitioners, Pet. Br. 24-25, is not to the contrary. In that case, the Secretary was under a final, non-appealable judgment, entered prior to *Georgetown*, requiring "reimbursement of any costs the providers could establish were reasonable, even if total routine costs exceeded the limitations." *Eskaton American River Hosp.* v. *Aetna Life Ins. Co.*, [1990 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 38,279, at 21,549 (Nov. 27, 1989), citing *Sutter Community Hospitals* v. *Heckler*, *supra*. The fact that the Secretary, after *Georgetown*, chose not to attempt to apply *Georgetown*'s holding in such a pending case surely does not indicate any relevant inconsistency. See *United States* v. *Mendoza*, 464 U.S. 154, 160-161 (1984). Indeed, petitioners appear to suggest that in order to avoid any embarrassing "inconsistency" the Secretary should have taken a position that would have led to litigation in a circuit that had already ruled against the government's position on the issue. See *Regents* v. *Heckler*, *supra*.

The HCFA Ruling cited by petitioners (Br. 25 n.21) is similar. HCFA Ruling No. 89-2, [1990 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 38,236, at 21,297 (Oct. 31, 1989). It dealt with the reimbursement of costs incurred by health maintenance organizations and competitive medical plans, which at the time were subject to absolute cost limits similar to those at issue here, but

fact that the Secretary once took a somewhat broader view of clause (ii) does not excuse the courts from according deference to the Secretary's current interpretation, especially since that interpretation is identical to the Secretary's interpretation of clause (ii) immediately after its enactment, and has been incorporated in book-balancing regulations that have remained in effect ever since. That interpretation accords clause (ii) its proper and accustomed role in the complex system of Medicare reimbursement, and preserves the integrity of the cost limits that Congress authorized to promote efficiency and fairness among providers and to facilitate administration of the program through rules of general applicability. By contrast, petitioners' expansive view of clause (ii) would undermine the cost limits, require *ad hoc* decisionmaking concerning the amount of reimbursement owed to thousands of providers annually (see note 3, *supra*), and

with no provision for exceptions such as those available under 42 C.F.R. 413.30(f). The ruling announced (1) that in light of *Medical Center Hospital* v. *Bowen*, *supra*, and *Regents* v. *Heckler*, *supra*, the relevant regulations would be revised to provide appropriate exceptions, and (2) that although, in light of *Georgetown*'s disapproval of retroactive cost-limit regulations, the new regulations would not be retroactive, as a matter of enforcement policy the absolute limits would not be applied pending revision of the regulations. The ruling did not consider the continuing validity of *Medical Center Hospital* and *Regents* in light of *Georgetown*'s construction of clause (ii). Moreover, the ruling relates to clause (ii) solely because of the similar language adopted by Congress in 1972 in 42 U.S.C. 1395mm(h)(3), governing "reasonable cost" reimbursement to health maintenance organizations. If anything, that Section's language (providing for "suitable retroactive corrective adjustments *at the end of each contract year*" (emphasis added)) and structure (as an alternative to an incentive payment system premised on year-end accounting) support the Secretary's construction of the same phrase as used in clause (ii). In any event, the ruling is consistent with the proposition that any obligation to provide appropriate adjustments to cost limits of general applicability is satisfied by the exemptions and exceptions provided by the cost-limit regulations. See pages 31-32, *supra*.

thereby undermine the statutory goals of efficiency, fairness, and ease of administration.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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DECEMBER 1992

☆ U. S. GOVERNMENT PRINTING OFFICE: 1992 342479 60128

Supreme Court, U.S.
FILED
FEB 2 1993
OFFICE OF THE CLERK

No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

v.

DONNA E. SHALALA, PH.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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REPLY BRIEF FOR THE PETITIONERS

Introduction

In our opening brief, we showed that clause (ii), as this Court repeatedly ruled in *Georgetown*, requires a three-step process:

> (1) determine what amount is owed under the Secretary's regulations for a fiscal period—*i.e.*, "for any fiscal period, the aggregate reimbursement produced by the methods of determining costs";
>
> (2) determine whether that amount is too low or too high—"adequate or excessive," *i.e.*, less or more than the "reasonable cost," which is "the cost actually in-

curred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services" (§ 1395x(v)(1)(A)); and

(3) adjust the amount paid (up or down) to eliminate the inadequacy or excess—*i.e.*, make "suitable retroactive corrective adjustments."

This is the plain, simple, and unambiguous meaning of clause (ii). It is precisely how this Court read clause (ii) four times in *Georgetown*. It is supported by the legislative history and neither is, nor can be, contradicted by any legitimate contrary regulatory interpretation.

The government urges a different "construction," which it refers to as the "book-balancing" view. What the government means by this label is *not* that, at the end of any fiscal period, the "books" must be retroactively "balanced" to ensure proper payments are made for that period under the *statutory* reasonable cost standard of § 1395x(v)(1)(A), *i.e.*, the form of reconciliation that petitioners assert clause (ii) unmistakenly requires. Instead, the government proposes that the books are to be mechanically balanced *only* to ensure that the "interim" payments made during the year (under a different section, § 1395g) are adjusted so that the total payment for the period conforms with the *regulatory* standards, even if those standards, as applied to a particular provider, do not produce payments equalling the statutory standard of reasonable costs as required by § 1395x(v). This view, which accomplishes only the first of the three steps required by clause (ii) and which by definition may leave providers under- or overpaid, is simply insupportable as an interpretation of clause (ii).

A. *The Secretary's Construction Of Clause (ii) Is Strained*

The Secretary points to essentially four aspects of the statutory language that she says supports her reading. These

efforts to fit her view into the text stretch any fair notion of textual interpretation well beyond the breaking point.

First, contrary to the Secretary's assertion (Gov't. Br. 16), nothing in the use of the term "retroactive" suggests that the adjustments are to be made only to conform interim payments to amounts due under the regulatory standards. Rather, that term merely indicates that it is at the end of the fiscal period that the comparison is to be made between amounts produced under the regulatory methods and the amount properly due under the reasonable cost standard set by the statute. Obviously, the last of the total costs "actually incurred" that comprise the reasonable costs of the provider for a fiscal period will not have been incurred until midnight of the last day of that period. Thus any comparison of interim payments against actual costs must necessarily await the close of the fiscal period and be a retrospective assessment.

Second, the phrase "corrective adjustments" as used in clause (ii) naturally refers to the adjustments needed to correct the discrepancy between the amount produced under the regulatory methods and the amount properly due under the reasonable cost standard set by the statute. Nothing about the term "corrective" limits corrections to "inaccuracies in the *application* of reimbursement methods prescribed by regulation." Gov't. Br. 16 (emphasis added). Nor does anything about the term "corrective" suggest that the adjustments must only be the "modest" corrections envisioned under the Secretary's interpretation. *Id.* Rather, "corrective" means "to fix what is wrong," whatever that takes.

Similarly, and contrary to the Secretary's half-hearted suggestion that the word "suitable" is a delegation of discretionary power not to make any adjustment (Gov't. Br. 18), a "suitable" adjustment is simply that adjustment which precisely eliminates the inadequacy or excess. This term gives the Secretary no license to deny adjustments to providers when

the very point of clause (ii) is to require case-specific adjustments for all individual providers that need them.

Third, the reference in clause (ii) to "aggregate reimbursement" strongly undermines, rather than supports, the Secretary's view. What clause (ii) demands to be judged "inadequate or excessive" is precisely the "aggregate reimbursement produced by the methods of determining costs"—that is, the "total" or "combined" reimbursement resulting from all of the "methods" considered together. The Secretary concedes that the term "methods" comprises all of the Secretary's regulations for determining reasonable cost. Gov't. Br. 17. Yet the Secretary then ignores that meaning and asks the Court to interpret clause (ii) to require that only the *partial* reimbursement produced by the interim payment mechanism, which is not even a "method" of determining reasonable cost, be analyzed for inadequacy or excess. How can "aggregate," a word meaning "total" or "combined," be construed to mean only partial reimbursement? This is especially so where nothing in the rest of § 1395x(v)(1)(A) suggests that the term "methods" means anything other than the *final* application of regulatory standards to determine total allowable costs.[1]

Fourth, clause (ii)'s "inadequate or excessive" test does not refer to the Secretary's regulatory cost limits as the benchmark for judging inadequacy or excessiveness. Gov't. Br. 17-18. As the Secretary concedes, it is the "statutory standard of reasonableness" that determines whether the "aggregate reimbursement" is inadequate or excessive. Gov't. Br. 17. And that standard, far from being "unspecified" (Gov't. Br. 17-18), has a statutory definition contained in the very same paragraph of § 1395x(v)(1)(A): "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services."

[1] We disagree with the Secretary's assertion that our construction would "disaggregate" the analysis and permit a challenge to each and every method. Gov't. Br. 17. To the contrary, as even the Secretary argues, clause (ii) raises a "bottom line" issue, and that is what we have raised. The fact that the petitioners can point to one of the methods as the major culprit does not change the fact that our claim is that the bottom line reimbursement the petitioners received does not meet the standards set forth in the statutory definition of reasonable costs.

It is true that these costs "shall be determined in accordance with regulations" issued by the Secretary (Gov't. Br. 18), but Congress never intended this language to support the analysis the Secretary urges on the Court, a circular analysis from which there is no escape: *i.e.*, reasonable costs are to be determined by regulatory methods and, therefore, the only question is whether the costs are in accordance with the regulatory methods. Clause (ii) breaks that circle by providing for adjustments that meet the statutory standard *notwithstanding* the regulatory methods. Thus, the "regulations" must accomplish two tasks: (1) they must establish "methods" to be used in the first instance, and then (2) they must provide an adjustment mechanism when the methods produce inadequate or excessive reimbursement.[2]

The Secretary is not only unable to find support in the statutory language, but her argument runs directly counter to the text of clause (ii) and its relation to other provisions of the statute. Not a word in § 1395x(v)(1)(A) speaks of "interim" payments. This entire section is a definitional one; and the subsection at issue is concerned with the substantive entitlement of providers to "reasonable costs," not with the mechanism or timing of payments or audits. The latter question is

[2] Thus, in the absence of other regulations which provide for individualized adjustments for any provider where reimbursement under the regulations falls short of the statutory standard of actual, reasonable cost, the regulatory implementation of the authority to establish the Provider Reimbursement Review Board as a dispute resolution mechanism provides the procedures for the individualized corrective adjustments mandated by clause (ii). Pet. Br. 25-27. See p. 10, *infra*.

addressed in an entirely different provision, § 1395g.[3] If Congress had meant clause (ii) to be restricted to the task the government suggests, it could and surely would have referred to adjustments of the amount produced by the "interim payments under § 1395g." Instead, it required adjustments of the results of the "methods of determining costs"—which earlier sentences of § 1395x(v) make clear are the regulatory standards for reimbursement.

Similarly, Congress could easily have written clause (ii) to limit the required adjustments to those needed to conform payments to regulatory standards. It could have referred to "inaccuracies in the *application* of reimbursement methods prescribed by regulation" (Gov't. Br. 16) or to "aggregate reimbursement ultimately determined to be due to the provider *under* the regulations" (Gov't. Br. 16), or to the "aggregate amount actually found to be owing *under* the applicable methods prescribed" (Gov't. Br. 25), or to "correcting the results of the necessary inaccuracies involved in the interim cost estimation process" (Gov't. Br. 35), or to "'aggregate reimbursement' *within the framework* of the Secretary's reimbursement regulations" (Gov't. Br. 35 n. 23) (emphasis added in all quotes). Congress chose none of those expressions. Instead, Congress wrote clause (ii) plainly to require adjustments when the results of the regulatory methods themselves—the "aggregate reimbursement *produced by the methods of determining costs*"—prove too high or too low, necessarily using the statutory reasonable cost standard set out explicitly at the outset of the very paragraph of § 1395x(v)(1)(A) in which clause (ii) appears.

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[3] *See* pp. 8-9, *infra*.

B. The Legislative History Does Not Support The Secretary's Interpretation

The remarkable point about all of the Secretary's discussion of the legislative and regulatory history prior to the 1972 cost limits is how starkly it supports our view that the retroactive reconciliation contemplated by Congress in 1965 was adjustments to conform reimbursement to the *statutory* standard of actual reasonable cost, not just to the regulatory methods. The quotes cited by the Secretary from the Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance, 89th Cong., 2d. Sess. (1966), Gov't. Br. 23-25, with respect to congressional debate on the initial Medicare regulations, do indeed refer to retroactive adjustments. However, Congress considered the required reconciliation to be between interim payments and a provider's "actual costs," once those costs are known. For example, at these hearings the Chief Counsel to the Senate Finance Committee reviewed the legislative history on the enactment of Medicare, stating:

> . . .[W]hen they wrote their committee reports, they emphasized again that the reimbursement was to be for *actual cost*.

Id. at 95 (emphasis added). He also quoted the House report:

> In paying reasonable costs, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for *costs actually incurred*.

Id. at 96 (emphasis added). He then said:

> [T]here is probably some flexibility in the legislative history that would permit an estimate to be made of some of these costs, provided that adjustments, retroactive adjustments, which are authorized by statute, would re-

> capture any excess payments, any payment *in excess of cost*, or would provide for payments to hospitals to make up any shortage in *costs*.

Id. at 96 (emphasis added). Nothing in these quotes supports the Secretary's contention that reconciliation was to be made only to the regulatory methods instead of to the statutory standard of actual reasonable cost.[4]

The Secretary's arguments concerning § 1395g, while creative, are also without merit. The fact that there was no mention of § 1395g in the original promulgation of the regulations, Gov't. Br. 26 n.14, is of no import, for that is the only section of the statute that authorizes the interim payment mechanism which the Secretary concedes is an integral part of the original regulations. *Id.* at 21. That the Secretary neglected to cite the proper statutory authority for the payment mechanism when the regulations were first published cannot override the plain meaning of the statute.[5]

Moreover, the phrase "with necessary adjustments on account of previously made overpayments or underpayments" in § 1395g can just as easily be read to include the final adjustments after audit to reconcile interim payments with the amounts due under the regulatory methods, rather than limiting the

[4] The quote from Commissioner Ball, Gov't. Br. 24 n. 13, as the Secretary implicitly acknowledges by her minimal reliance on the point, is naturally read to refer only to the retroactive alteration of *rules*, which is exactly what *Georgetown* held was impermissible, in express contrast to the individual retroactive case-by-case adjustments required by clause (ii).

[5] Nor is petitioners' view of § 1395g a belated one, as the Secretary suggests. Gov't. Br. 26. In 1973 the very first court of appeals to construe the meaning of clause (ii) agreed with the petitioners' view that the "book balancing" provisions cited by the Secretary were in fact authorized by § 1395g and did not implement the mandate of clause (ii). *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973).

language to interim and pre-audit adjustments, as the Secretary would construe it. Indeed, the Secretary even states that § 1395g can be construed to authorize the final retroactive "book balancing" adjustments she claims are authorized by clause (ii). Gov't. Br. 27 n.16. This admission undermines the rest of the Secretary's interpretation of the relevant legislative history.

The logical and natural construction of the statutory scheme is that § 1395g governs both interim payments *and* the audit to apply the regulatory methods, with its mechanical adjustments between the interim payments and amounts due under the regulations. Yet the Secretary insists on a construction under which all the mechanics for paying providers and auditing them, including the assessment of interest on final determinations of overpayments, are governed by § 1395g, except the final adjustment after audit. This final adjustment to reconcile interim payments with amounts due under the regulations, the Secretary contends, is governed by the reasonable cost "definition" section of the statute, *i.e.*, clause (ii). Such a strained interpretation clearly runs counter to the organization and structure of the statute.[6]

Finally, it is evident that when Congress enacted the authority for the cost limits in 1972, it did not change the statutory

[6] The Secretary's position is further belied by the fact that post-audit adjustments to reconcile interim payments with amounts due under the regulations continue to be made for certain hospitals that are paid on a prospective "per discharge" basis under § 1395ww(d), rather than on a reasonable cost basis under § 1395x(v)(1)(A). *See* Provider Reimbursement Manual § 2405.1.B ("The [interim] payments [based on total estimated discharges] will be reviewed...and subject to final settlement at year end based on a reconciliation to total payments as determined on a per discharge basis.") Obviously § 1395g is the authority for those final post-audit adjustments, for the language in § 1395g is not limited to payment of reasonable costs, and there is no other statutory provision authorizing such a final reconciliation for PPS payments.

right to a case-by-case adjustment to ensure compliance with the statutory standard of reasonable cost, for the language in clause (ii) did not change. At the same time, Congress elaborated upon the *statutory* standard of reasonable costs, by adding to statutory definition of "reasonable cost" in the first sentence of § 1395x(v)(1)(A) the phrase: "excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." It is against this standard that since 1972 clause (ii) requires aggregate reimbursement to be measured.

The legislative history of the 1972 amendments shows that Congress also created the Provider Reimbursement Review Board at that time because the Secretary had not provided an adequate remedy to providers with regard to claimed shortfalls in reimbursement. H.R. Rep. No. 231, 92d Cong., 2d Sess. (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5094; S.Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). Providing such a remedy as part of the 1972 legislation is consistent with (1) the further definition of reasonable cost to exclude costs "found" to be unnecessary in the efficient delivery of health care services; and (2) the delegation of authority to promulgate cost limits. *See* Pet. Br. 25-27.[7]

[7] Indeed the broadly worded jurisdictional grant of the Board in 42 U.S.C. § 1395oo(a) provides that a hearing may be obtained by a provider "if such provider is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report." That grant encompasses both a claim that the provider was under-reimbursed within the context of the Secretary's regulations and a claim that the reimbursement produced by the regulations themselves is inadequate. Had the 1972 Congress intended what the Secretary now contends clause (ii) means, it need only have provided for a hearing for any provider "dissatisfied with the final determination . . . of the total program reimbursement due to provider *under the Secretary's regulations*. . . ."

In her brief the Secretary effectively ignores the fact that Congress intended the cost limits to be just another "method" of determining reasonable cost, presumptive only, and subject to the overriding mandate of clause (ii) whenever this method, along with the others, results in inadequate or excessive reimbursement under the statutory standard. Thus, every provider, not just those few which fall within narrow exceptions provided by the Secretary, could obtain an adjustment if they could show their costs met the statutory standard of reasonable cost as expanded by the 1972 amendments. "Providers would of course have the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." S. Rep. No. 1230, 92d Cong., 2d Sess. 189 (1972).

C. Georgetown Supports The Petitioners

No less than four times did this Court in *Georgetown* construe the plain language of clause (ii) in the way that petitioners construe it, *i.e.*, as requiring case-by-case adjustments where the regulatory methods do not reach correct results in individual cases. *See* Pet. Br. 14-15.[8] The Court's reference to the Secretary's previously inconsistent interpretation of clause (ii), 488 U.S. at 211-12 and n.2, was not an endorsement of that interpretation. Rather, the Court cited the Secretary's "book balancing" regulations only as a reason not to defer to the Secretary's position in *Georgetown* that clause (ii) authorized retroactive rulemaking. Thus, *Georgetown* cannot be read as implicitly affirming the Secretary's interpretation put forth in this case.

The Secretary also asserts that the petitioners' construction of the statute violates *Georgetown* because any relief the

[8] The petitioners agree that retroactive case-by-case adjustments downward are allowable under clause (ii).

petitioners would obtain by means of individual retroactive corrective adjustments is tantamount to a wholesale change in the cost limits methodology and is therefore retroactive rulemaking. Gov't. Br. 35.[9] This position of the Secretary is absurd. The logical extension of the Secretary's conclusion is that regulations can never be found to be invalid as written or as applied in an individual appeal because such a holding ultimately would have the effect of retroactive rulemaking.[10]

Nor are the petitioners seeking a "second bite of the apple." Gov't. Br. 36. Rather, the statute offers two different avenues of redress to the petitioners: one is the right to challenge the validity of a regulatory method (*see* § 1395oo(f)(1)); the other is the right to an adjustment even where *valid* regulatory methods are invalid as applied in a particular situation, *i.e.*, where they do not reimburse actual reasonable cost (clause (ii)). Providers may seek relief under either one of these provisions, or under both.[11] The fact that petitioners now seek

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[9] The Secretary notes that petitioners asked for an 11% adjustment to the rural Nebraska wage index, which would result in an impermissible retroactive change to the cost limit "method" in violation of *Georgetown*. Gov't. Br. 35 n. 24. The petitioners did suggest, based on a study which analyzed the use of part-time employees in Nebraska vis-a-vis the rest of the country, that an 11% adjustment to the rural Nebraska wage index would be a "suitable" retroactive corrective adjustment for their situation. However, in the alternative, they asked the court of appeals for a remand to the PRRB to demonstrate that their costs in excess of the limits are reasonable. Pet. C.A. Rep. Br. 16-17.

[10] Such a result is directly contrary to the remedy granted for PRRB review of the application of regulations and judicial review of the validity of regulations in 42 U.S.C. § 1395oo.

[11] Indeed, had petitioners not also challenged the validity of the cost limits, the Secretary would be arguing that is what we should have challenged so that he could consider the merits of the regulations in the context of our challenge under clause (ii). *Association of American Medical Colleges v. Califano*, 569 F.2d 101 (D.C. Cir. 1977).

Moreover, the Medicare program's statutory obligation to pay providers the reasonable cost of caring for Medicare beneficiaries has not been

a clause (ii) adjustment where a valid regulatory method (the cost limits) produce inadequate reimbursement of their actual reasonable costs is not an impermissible "second bite."

The Secretary's threats of a floodgate of individual appeals should not persuade the Court to adopt the Secretary's narrow and strained reading of the statute. Clause (ii) is no longer applicable to many providers.[12] Moreover, not every provider

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negated simply because the use of "BLS data caus[ing] unavoidable distortions" has been sustained as "the best [data] source currently available" for constructing a national wage index. The burden of proof falls on the provider—or the government—to show under clause (ii) how aggregate reimbursement—for whatever cause—is inadequate or excessive in an individual instance.

This function served by clause (ii), *i.e.*, individualized adjustments, has long been recognized as central to a workable regulatory scheme. For example, in *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956), this Court upheld a regulation limiting any applicant for a broadcasting license to an interest in a maximum number of stations. The necessary flexibility, the Court found, was provided through the availability of a full hearing for individual applicants that might show why, in their case, the rule should be waived or amended. Again, in *FPC v. Texaco, Inc.*, 377 U.S. 33, 41, (1964), this Court upheld a regulation barring from consideration for a certificate of public convenience and necessity any natural gas supplier that included certain price clauses in its contracts with pipeline companies. As in *Storer*, the Court found determinative the opportunity afforded individual regulated entities to show that the rule was invalid as applied in its case. *See also Pacific Gas & Electric Co. v. FPC*, 506 F.2d 33, 38 (D.C. Cir. 1974).

[12] Most hospitals are now paid under the prospective payment system, 42 U.S.C. § 1395ww(d), rather than under the reasonable cost methodology with its clause (ii) adjustment. Although certain specialty hospitals exempt from PPS (*e.g.*, rehabilitation, psychiatric) continue to be paid on the basis of reasonable costs, their reimbursement is subject to an absolute per discharge limit under 42 U.S.C. § 1395ww(b) which is not subject to a clause (ii) adjustment. A third of Medicare skilled nursing facilities are reimbursed under a prospective payment methodology rather than the reasonable cost method. *See* 42 U.S.C. § 1395yy(d). Although

to which clause (ii) applies can show that its costs in excess of the limits are reasonable. Only in situations such as this, where the underpayment is substantial enough to warrant the time and expense of litigation and where the provider believes it can meet the burden of proof by demonstrating that its actual costs are not "unnecessary in the efficient delivery of needed health services," would a provider consider undertaking the task. A provider is not likely to initiate such an appeal lightly. *See* Amicus Br. 26-28. Further, no argument of administrative burden can overcome the right to an adjustment granted by the plain language of the statute. *EEOC v. Associated Dry Goods Corp.*, 449 U.S. 590, 604-605 (1981).

D. The Secretary's Position Deserves No Deference

In this case there is clearly no basis for deference. "[A] pure question of statutory construction [is] for the courts to decide." *INS v. Cardoza - Fonseca*, 480 U.S. 421, 446 (1987). *See also Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 and n.9 (1984). Where the statutory language is unambiguous, courts cannot defer to a contrary agency interpretation. *Pittston Coal Group v. Sebbin*, 109 S. Ct. 414, 420 (1988).

The Secretary offers nothing but excuses for its concededly shifting positions on what clause (ii) means, all designed to escape the plain meaning of the statute. The alleged "disarray" in the lower courts did not cause the Secretary's inconsistency.[13] Neither Congress nor the courts ordered the Sec-

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home health agencies are still cost reimbursed, they generally are relatively small providers that cannot afford to pursue such appeals.

[13] It is misleading for the Secretary to imply that *Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger*, 376 F.Supp. 1099 (S.D. Fla. 1974), *rev'd*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, 425 U.S. 935 (1976), supports the bookbalancing view espoused by the Secretary in this case, *i.e.*, that § 1395g only authorizes pre-audit adjustments while clause (ii) is the authority for post-audit final adjustments. Gov't. Br. 38. The issue in *Mt. Sinai* was whether § 1395g authorized adjustments for overpayments due to *coverage* denials. Significantly, it was the Secretary who, in 1972, invoked § 1395g as authority for suspending payments to providers when final audits indicated there were overpayments due to coverage determinations. 376 F. Supp. at 1127. The district court and court of appeals rejected the Secretary's position and construed § 1395g and clause (ii) together to conclude that those provisions related to *cost* determinations rather than coverage determinations. But the courts did not in any way adopt the dichotomy that § 1395g relates only to pre-audit adjustments while clause (ii) authorizes the final adjustment after audit.

retary to take inconsistent but convenient litigating positions. Rather, the inconsistency in the Secretary's positions demonstrates that the Secretary feels free to ascribe to language a meaning that is convenient to whatever issue the Secretary is litigating at the time. This case is no exception.

Finally, the cases cited by the Secretary for the proposition that a contemporaneous interpretation of a statute by the agency charged with its implementation is entitled to great weight, Gov't. Br. 22, are inapposite here, for implicit in those cases is the assumption that the agency's position has been consistent.[14] Where, as here, the agency's construction changes over time to suit its immediate needs, and where it is inconsistent with the plain language of the statute, no deference should be given. *EEOC v. Arabian American Oil Co.*, 111 S. Ct. 1227, 1235 (1991); *National Muffler Dealers Ass'n, Inc. v. U.S.*, 440 U.S. 472, 477 (1979); *Southeastern Community College v. Davis*, 442 U.S. 379, 411-12 and n. 11 (1979); *Morton v. Ruiz*, 415 U.S. 199, 238 (1974).

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[14] In *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 382 (1969), the Court explicitly referred to 30 years of consistent agency interpretation.

CONCLUSION

For the foregoing reasons, the petitioners request that the decision of the court of appeals be reversed and that this case be remanded to the Provider Reimbursement Review Board where the petitioners shall have the opportunity to demonstrate that their costs in excess of the cost limits are reasonable.

Respectfully submitted,

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Supreme Court, U.S.
FILED
NOV 23 1992
OFFICE OF THE CLERK

No. 91-2079

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, *et al.*,
Petitioners,

v.

LOUIS W. SULLIVAN, M.D.,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AS *AMICUS CURIAE* ON BEHALF OF PETITIONERS

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BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AS *AMICUS CURIAE* ON BEHALF OF PETITIONERS

INTEREST OF *AMICUS CURIAE*

Amicus curiae American Health Care Association ("AHCA") is the largest national trade association representing the long term care (nursing home) industry. AHCA is a private, voluntary, nonprofit federation of 51 affiliated State associations representing more than 11,000 non-profit and proprietary long term care providers that care for over 1.1 million nursing home residents. As such, AHCA represents about two-thirds of the nation's 16,000 nursing homes, many of which provide skilled nursing facility ("SNF") services to eligible beneficiaries under the federal Medicare program.

Assuring high quality SNF services requires the hard work and cooperation of many dedicated health care professionals and non-professional staff. Further, the experience of AHCA's members has shown that there is a vital link between the ability of nursing homes to provide such care and the adequacy of the payment rates they receive.

Like the petitioner hospitals during the cost periods at issue in this case, nursing homes that participate in Medicare as SNFs receive reimbursement for the lesser of their "reasonable cost" of providing SNF services to Medicare patients or their "customary charges" with respect to such services. 42 U.S.C. § 1395f(b)(1) (1988 & Supp. 1990). While this "reasonable cost" reimbursement has now been replaced for most hospitals by a prospective payment system, SNFs continue to be reimbursed on a "reasonable cost" basis. AHCA's interest in this case is its concern that individual nursing homes preserve their ability to secure "reasonable cost" reimbursement—through retroactive corrective adjustments under 42 U.S.C. § 1395x(v)(1)(A)(ii)—which accounts for the true, necessary costs of SNF services to Medicare

patients, even where the Secretary's substantive regulatory reimbursement methods do not pay the reasonable cost of those services.[1]

BACKGROUND ON THE MEDICARE PROGRAM AND REASONABLE COST REIMBURSEMENT OF SNFS

A. The Medicare Program

The Medicare program provides a nationwide, federally-funded health insurance program for the elderly. The Secretary of Health and Human Services ("Secretary") has delegated authority to administer the Medicare program to the Health Care Financing Administration ("HCFA"). The program consists of two parts, Part A and Part B, each of which has separate rules, requirements, and funding mechanisms. Medicare Part A, the Hospital Insurance Program at issue in this case, pays for inpatient hospital, SNF, home health, hospice, and certain dialysis services through mandatory taxes on workers' wages. 42 U.S.C. §§ 1395d(a), 1395i, 1395rr(a) (1988 & Supp. 1990).

Medicare Part A covers up to 100 days of SNF services per spell of illness, following a prior hospitalization. *Id.* §§ 1395d(a)(2), 1395x(i) (1988 & Supp. 1990). In order to be reimbursed for such services, however, a nursing home must meet a variety of "participation requirements" and be certified as a SNF. *See id.* § 1395i-3(g) (1988 & Supp. 1990). As part of the Omnibus Budget Reconciliation Act of 1987 ("OBRA 1987"), Congress enacted a comprehensive series of nursing home reforms to these participation requirements, which are equally applicable to the Medicaid program.[2] Most of

[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

[2] The Medicaid program is a joint federal-state welfare program authorized under Title XIX of the Social Security Act to provide medical care for the indigent. *See* 42 U.S.C. § 1396 *et seq.* (1988 & Supp. 1990). Under Medicaid, states become eligible for federal matching funds by submitting a "state plan" to the Secretary which conforms to federal requirements. Medicaid covers "nursing facility" ("NF") care, which includes care of individuals whose medical needs are not acute enough to qualify for Medicare SNF benefits or whose needs are equally acute but who do not qualify for Medicare SNF benefits on other grounds. *Id.* §§ 1396d(a)(4), 1396(f), 1396r (1988 & Supp. 1990).

these reforms became effective October 1, 1990. OBRA 1987, § 4204(a), P.L. 100-203, 101 Stat. 1330, 1330-182. On a general level, OBRA 1987 requires a SNF to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ." 42 U.S.C. § 1395i-3(b)(2) (1988). Among the more specific OBRA 1987 provisions are requirements relating to individualized assessments, reviews, and plans of care for each resident; minimum nurse staffing standards; training, testing, and continuing education of nurse aides; provision of social services; and management of residents' personal funds. *See id.* §§ 1395i-3(b)-(c) (1988 & Supp. 1990).

B. Medicare Reimbursement Of SNFs

Medicare pays SNFs (as it did the petitioner hospitals in the cost years under appeal) an amount equal to the lesser of their "reasonable costs" for SNF services or their "customary charges" for such services. 42 U.S.C. § 1395f(b)(1). This system is generally referred to as the "reasonable cost" methodology. Under this system, which remains in effect for SNFs,[3] providers of services file annual cost reports which are then audited by the Secretary's agents (commonly known as "fiscal intermediaries") to determine, on a *retrospective* basis, whether the costs that were actually incurred were "reasonable." *Id.* at §§ 1320a, 1395h (1988 & Supp. 1990).

The Medicare statute defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient

[3] As noted earlier, Medicare no longer reimburses most hospitals on a "reasonable cost" basis. Instead, Medicare now generally pays for inpatient hospital services using a "prospective payment" methodology. *See id.* § 1395ww (1988 & Supp. 1990).

delivery of needed health services . . . ." *Id.* § 1395x (v)(1)(A) (1988). The statute further provides that reasonable costs "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs." *Id.* The methods of reimbursement *may*: (1) allow for the determination of costs on a per diem, per unit, per capita, or other basis; (2) take into account differing circumstances; (3) use estimates of costs of particular items and services; (4) establish cost limits on overall costs or costs of specific items; and (5) base reimbursement on a provider's charges. *Id.* On the other hand, the reasonable cost regulations *must*:

> (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by insurance programs established by this title will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

Id. In the SNF context, the reimbursement methods must also take into account, in a manner consistent with the above provisions, the per-diem costs to SNFs of complying with OBRA 1987's nursing home reforms. *Id.* § 1395x(v)(1)(E) (1988 & Supp. 1990).

The Secretary's regulations governing reasonable cost reimbursement appear at 42 C.F.R. § 413.1 *et seq.* Among other things, those regulations include the "methods" for (1) defining what types of costs are "allowable" for reimbursement, (2) allocating direct and indirect costs among the various operational functions of a provider ("cost finding"), and (3) apportioning a provider's total allowable costs among its Medicare and non-Medicare patients ("cost apportionment"). *See* 42 C.F.R. §§ 413.24, 413.53, 413.80 *et seq.* (1991). The Secretary's regulations do not provide an explicit mechanism for making retroactive corrective adjustments to reimbursement where these methods produce substantively inadequate reimbursement.

In addition to the general authority under 42 U.S.C. § 1395x(v)(1)(A), the Medicare statute contains additional authority for using prospective cost limits (*i.e.*, limits developed in advance of the rate period) for SNFs. Specifically, 42 U.S.C. § 1395yy requires the Secretary to recognize a SNF's "routine service costs" as reasonable only if they fall within specified percentages of the mean routine service costs for comparable SNFs. These "routine cost limits" must take into account geographical wage differences, must be updated periodically, and may be adjusted for a particular SNF based upon the acuity levels of its patients or "circumstances beyond the control of the facility." 42 U.S.C. § 1395yy(a)-(c) (1988 & Supp. 1990).[4]

The Secretary has invoked the authorities described above to promulgate "cost limits" applicable to SNFs, similar to the hospital cost limits challenged by petitioners below. Both hospitals and SNFs may request "exemptions" from or "exceptions" to (*i.e.*, upward revision of) the cost limits. 42 C.F.R. § 413.30(e) (1991). The SNF exemptions and exceptions are fewer in number than those available for hospitals, however. Whereas a hospital may seek an exemption as a sole community provider, new provider, or rural provider with less than 50 beds, a SNF may only obtain an exemption if it meets the

[4] When 42 U.S.C. § 1395yy was enacted as Section 2319 of the Deficit Reduction Act of 1984, P.L. 98-369, 98 Stat. 494, 1082, both the terms of the legislation itself and its legislative history explained that exceptions would be available to ensure that SNFs could justify their reasonable costs. 42 U.S.C. § 1395yy(b); Staff of Senate Comm. on Finance, 98th Cong., 2d Sess., Explanation of Provisions Approved by the Committee on March 21, 1984 at 948 (Comm. Print 1984). As explained in Section I.B.2., *infra*, Congress made similar statements when the Secretary was given general authority to promulgate cost limits in 1972.

"new provider" criteria. *Id.* § 413.30(e) (1991). Similarly, under the regulations, hospitals may obtain exceptions for atypical services, extraordinary circumstances, geographic location, medical education programs, more intensive routine care, essential community hospital status, unusual labor cost, or changes in case mix. The only regulatory exceptions available to SNFs, on the other hand, are for atypical services, extraordinary circumstances, geographic location, and unusual labor cost. *Id.* § 413.30(f) (1991).

Equally as important, the exemptions and exceptions available to SNFs are extremely narrow or only apply to certain limited categories of costs. For example, the "extraordinary circumstances" exception only applies to events such as "strikes, fire, earthquake, [or] flood." *Id.* § 413.30(f)(2). The "geographic location" exception only allows upward revision of the cost limits where a provider is located in an area (such as a resort) with a routinely fluctuating population, and then only if a state agency makes certain findings concerning the supply of services in that area. *Id.* § 413.30(f)(3). None of the SNF cost limit exceptions covers situations where the Secretary's methodology for computing the cost limits does not account for local circumstances or contains a "formulaic" defect (*e.g.*, the use of an improper index or erroneous data) that has systemic implications or adversely affects individual providers.

SUMMARY OF ARGUMENT

Medicare providers paid under a reasonable cost system are entitled to retroactive corrective adjustments whenever the Secretary's methods of determining reasonable costs produce an inadequate or excessive result. 42 U.S.C. § 1395x(v)(1)(A)(ii) (1988 & Supp. 1990) ("clause (ii)"). As the plain language of clause (ii) reflects, these adjustments are substantive in nature, and are designed to effectuate the Medicare statute's mandate that all reasonable costs be reimbursed. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 209-11 (1988).

Contrary to the Secretary's position in this and other cases, neither the "book balancing" regulations at 42 C.F.R. § 413.60-.64 nor the narrow regulatory exceptions to the cost limits at 42 C.F.R. § 413.30 implement clause (ii). The book balancing regulations do not provide for any substantive methodological adjustment to reimbursement. Similarly, the cost limit exceptions provide only limited adjustments to account for specified deficiencies in a single method, whereas the statute requires adjustments where *any* of the "methods" produce an inadequate result.

In limited contexts, the Secretary has effectively admitted that retroactive corrective adjustments are necessary to implement the statutory mandate of reasonable cost reimbursement. For example, the Secretary has disavowed his intention to enforce conclusive limits on certain health maintenance organizations in light of judicial decisions requiring a "retroactive corrective adjustment." He has also provided individual SNFs with an opportunity to prove their costs of implementing OBRA 1987 are reasonable even if those costs exceed his estimates.

Likewise, substantive retroactive corrective adjustments do not violate *Georgetown*'s prohibition against retroactive rulemaking, because such adjustments would take the form of adjudication rather than rulemaking. Further, such adjustments do not violate *Georgetown* because, as the statute makes clear, they are made to "aggregate reimbursement" rather than to the regulatory "methods" themselves.

As a practical matter, substantive retroactive corrective adjustments are necessary because of the inexact and evolving nature of ratesetting. The ratesetting process constantly must address changing federal, state, and local legal and business conditions. In many cases, no historical cost data exist from which to adjust reimbursement rates, and the Secretary must make reasonable estimates and assumptions based on the best available information to project reasonable costs on a prospective basis (*i.e.*, before adequate cost data are avail-

able). By the same token, however, the imperfection and imprecision of this process mean that retoractive corrective adjustments are necessary in order both to correct errors in estimates and assumptions and to recognize that individual providers may warrant exceptions to those estimates and assumptions.

Finally, recognition of substantive retroactive corrective adjustments by the Court would not result in numerous clause (ii) cases being filed in federal court. As a practical and jurisdictional matter, those cases must involve major reimbursement deficiencies in order to be cost-effective; the lack of a substantial number of such cases in the 27-year history of the Medicare statute bears this out. Indeed, recognition of a substantive right under clause (ii) would promote more efficient resolution of reimbursement disputes than at present.

ARGUMENT

I. CLAUSE (ii) OF 42 U.S.C. § 1395x(v)(1)(A) REQUIRES SUBSTANTIVE RETROACTIVE CORRECTIVE ADJUSTMENTS TO AN INDIVIDUAL PROVIDER'S REIMBURSEMMENT WHENEVER THE AMOUNT OF REIMBURSEMENT PRODUCED BY THE SECRETARY'S REGULATORY METHODS FAILS TO COVER A PROVIDER'S ACTUAL REASONABLE COSTS.

At bottom, this case is about whether the Secretary's duty to reimburse Medicare providers for their full reasonable costs is qualified or absolute. The language of clause (ii) and the Secretary's own recent conduct make clear that the duty is absolute and is not satisfied by mere "book balancing" adjustments or narrow cost limit exceptions. Instead, clause (ii) requires substantive adjustments to individual providers' reimbursement where the regulatory methods produce an inadequate result. Such adjustments need not alter the methods themselves, however, and therefore do not violate *Georgetown*'s prohibition against retroactive rulemaking.

A. The Plain Language Of Clause (ii) Requires Substantive Adjustments To Reimbursement To Account For Reasonable Costs.

"Reasonable costs" under the Medicare statute are those costs "actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services." 42 U.S.C. § 1395x(v)(1)(A). The statute authorizes the Secretary to develop the "method or methods" to be used to "determine" such costs. The statutory definition of reasonable costs makes clear, however, that the Secretary's authority to promulgate regulations establishing the methods for identifying such costs (including potential methods such as cost limits) does not diminish his statutory duty to reimburse reasonable costs in full.

The final sentence of 42 U.S.C. § 1395x(v)(1)(A) confirms this duty by establishing mandatory minimum standards that the Secretary's regulations must meet. Clause (i) essentially prohibits regulatory methods that would result in "cross-subsidization" of Medicare services, *i.e.*, payment for the reasonable costs of those services from other sources as a result of "cost-shifting." In other words, clause (i) confirms the Secretary's duty to reimburse Medicare reasonable costs *in full*.

Clause (ii) requires "suitable retroactive corrective adjustments" where the "methods of determining costs" yield either "inadequate or excessive" reimbursement to a provider. This requirement creates a substantive right that enables health care providers to enforce, through case-by-case adjudication, the Secretary's duty to reimburse reasonable costs in full. *Georgetown*, 488 U.S. at 209-10. The language of clause (ii) clearly contemplates "substantive" adjustments to a provider's reimbursement. First, clause (ii) on its face requires adjustments to the "reimbursement produced by the methods." In other words, the Secretary's regulatory methods for determining reasonable costs are always subject to his duty to reimburse an individual provider's reasonable costs in full even where the methods are otherwise valid. *Regents*

of Univ. of Cal. v. Heckler, 771 F.2d 1182, 1189 (9th Cir. 1985). Second, the use of the terms "inadequate" and "excessive" to modify "reimbursement" and the description of adjustments as "corrective" both suggest adjustments for substantive reimbursement disparities.

B. Neither The Secretary's "Book Balancing" Regulations Nor The Secretary's Exceptions To The Cost Limits Satisfy The Requirement For Retroactive Corrective Adjustments Under Clause (ii).

Historically, the Secretary has posited two principal alternative theories of how he has satisfied his duties under clause (ii): the "book balancing" regulations at 42 C.F.R. § 413.60-.64; and the "cost limit exceptions" at 42 C.F.R. § 413.30(f). Neither set of regulations fully satisfies the mandate of clause (ii), however. Moreover, the Secretary's actions with respect to reimbursement of SNFs and other types of providers belie his arguments.

1. *The "book balancing" regulations do not satisfy the Secretary's duties under clause (ii).*

Under the reasonable cost reimbursement system, the Medicare program periodically pays providers an "interim" rate during the course of a cost year. These interim rates are based on the provider's actual reasonable costs in the past. 42 C.F.R. § 413.64(a) (1991). This system allows providers to obtain sufficient cash flow to sustain their Medicare operations, while avoiding the continual need to submit documentation of costs (and the corresponding burden on the Secretary to process cost claims). At the end of the cost period, the provider then submits a cost report, which the Secretary audits in accordance with the regulatory methods for determining reasonable costs. Once the Secretary determines the total amount to be reimbursed, this amount is then reconciled (upwards or downwards) with the total interim payments. *Id.* §§ 413.60(c), 413.64(f) (1991). In short, the year-end reconciliation is not a "method" of reimbursement because it does not make any substantive adjustment to the provider's reasonable cost reimbursement. Rather, it is merely a payment procedure designed to minimize administrative burdens for the Medicare program while ensuring adequate cash flow for its providers.

Aside from the actual failure of the book balancing regulations to produce the substantive adjustments required under clause (ii), the text and structure of the Medicare statute further confirm that the book balancing regulations do not implement clause (ii). Even if the interim rate could be deemed a "reasonable cost" method, clause (ii) requires adjustments when *any* of the "methods" produce inadequate reimbursement. If clause (ii) were fully implemented by the book balancing regulations, the statute's use of the plural would not be given full effect because *only* the single payment "method" of interim payments could produce an inadequate or excessive result.

In addition, the book balancing regulations are authorized under a separate section of the Medicare statute which describes the mechanics of payment and requires "adjustments on account of previously made overpayments or underpayments." 42 U.S.C. § 1395g(a) (1988). The book balancing regulations' reconciliation process accounts for these "overpayments and underpayments" rather than for "inadequate or excessive" reimbursement.

Finally, *Georgetown* did not hold or imply that the book balancing regulations meet the Secretary's duty to provide for retroactive corrective adjustments under clause (ii). Instead, the Court expressly recognized on several occasions that clause (ii) calls for substantive adjustments to an individual provider's reimbursement whenever the methods produce an inadequate result. *See* 488 U.S. at 209-11. The Court's only discussion of the book-balancing regulations was not a ruling on what clause (ii) requires, but rather was part of a broader rejection of the Secretary's position that clause (ii) permits retroactive rulemaking. *See id.* at 211 & n.2. The issue of what clause (ii) requires is squarely before the Court in *this* case.

2. *The cost limit exceptions do not fully implement clause (ii).*

The Secretary's brief in response to the petition for certiorari suggests that he also believes that the cost limit exceptions satisfy his duties with respect to clause (ii). That position again overlooks the narrow coverage of the exceptions, the language of clause (ii), and the legislative history of the cost limits.

Clause (ii) requires retroactive corrective adjustments whenever *any* of the "methods" of determining reasonable costs results in inadequate reimbursement. It does not merely authorize special rules when the method in question is a cost limit. *See Regents*, 771 F.2d at 1189. The cost limit exceptions, on the other hand, are narrowly tailored, particularly as they apply to SNFs. The Secretary's argument that the exceptions implement clause (ii) is therefore inconsistent with the use of the plural term "methods," because the narrow exceptions clearly do not provide for adjustments where the cost limits—or other reimbursement "methods"—result in inadequate aggregate reimbursement and the nature of the deficiency does not fall neatly within one of the enumerated exceptions.[5] As the Eleventh Circuit noted in *Medical Center Hospital v. Bowen*, 839 F.2d 1504, 1511 (11th Cir. 1988), "We can imagine myriad situations where resort to the Secretary's exceptions process would not result in the provider receiving the full reimbursement to which it is entitled under the statute." In short, clause (ii) requires adjustments with respect to inadequate reimbursement regardless of the reimbursement method at fault, but the cost limit exceptions clearly do not provide such relief.

Moreover, as petitioners explain in greater detail, the legislative history to congressional authorization of cost limits clearly indicates that such limits were designed to be purely presumptive and that providers would be able

[5] An example of a method other than the cost limits which may inadequately reimburse individual SNFs, even though such method may not be invalid across-the-board, is discussed *infra* in Part II.B.

to obtain relief from the limits on the basis of evidence of reasonable costs. *See* S. Rep. 1230, 92d Cong., 2d Sess. 188-89 (1972); H.R. Rep. No. 231, 92d Cong., 1st Sess. 83-85 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5070-71. Even the Secretary recognized the imperfect nature of the cost limits from their outset. *See* 39 Fed. Reg. 20,164 (Jun. 6, 1974) (noting that the proposed limits were not as "refined" or "advanced" as those that might be possible in the future).[6] One additional point bears note, however: insofar as the substantive adjustment requirements of clause (ii) predated the 1972 authorization for cost limits, the more rational construction of the cost limit exceptions is that they merely define some circumstances under which those limits do not apply. They are not the sole or exclusive means of implementing clause (ii).[7]

[6] Moreover, the Secretary argues that the cost limits are conclusive as to costs in excess of the limits except under the narrow exceptions in the regulations, while in practice he treats the cost limits as merely being broadly presumptive when costs are below the limits. In other words, a provider having costs below the limits is not simply paid these costs, but rather the Secretary remains free to make further disallowances if he finds that the costs are not reasonable, necessary, proper, or related to patient care. *See* 42 C.F.R. § 413.9 (1991). Why the Secretary can make wide-ranging determinations of "reasonableness" as to the costs of providers below the limits, while he cannot do so for provider costs above the limits (or in excess of other methods) seems inexplicable.

[7] The Secretary's argument concerning the meaning of clause (ii) is clearly inconsistent. On the one hand, he seems to suggest that, before 1972, clause (ii) required only book balancing regulations to reconcile interim and final payments. On the other hand, he appears to contend that, even though clause (ii) was not altered or amended in any way, it suddenly required substantive corrective adjustments after 1972 to payments produced by the rate methods—but only insofar as they involved certain narrow exceptions to the cost limits method. There is no statutory basis or legislative history to support this contention.

3. *The Secretary's recent administration of the reasonable cost reimbursement system for health maintenance organizations and SNFs demonstrates his acknowledgment of his duty to provide substantive retroactive corrective adjustments.*

Two recent examples of the Secretary's administration of Medicare's reasonable cost reimbursement system demonstrate that he recognizes that the duty to provide retroactive corrective adjustments is not limited to either book balancing or cost limit exceptions, but rather involves substantive adjustments to reimbursement.

First, in 1989 (after *Georgetown*) the Secretary issued a formal ruling applicable to reimbursement of Medicare cost-based health maintenance organizations ("HMOs").[8] Similar to other reasonable cost providers, cost-based HMOs are entitled to "appropriate retroactive corrective adjustment[s] at the end of each contract year so as to assure that such organization[s are] paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) . . . ." *Id.* § 1395mm(h)(3). In 1985, however, the Secretary issued a rule that applied the 95 percent per capita rate normally applicable to risk-based HMOs as "an absolute limitation on the total amount payable" to cost-based HMOs. 42 C.F.R. § 417.532(a)(3) (1991).

Four years later, the Secretary issued a policy statement disavowing his intention to enforce § 417.532. In that ruling, the Secretary specifically acknowledged the identical meanings of the "retroactive corrective adjustment" language in clause (ii) and the HMO statute, and explicitly based his decision not to enforce the regulation on the clause (ii) decisions in *Medical Center Hospital* and *Regents*. HCFA Ruling 89-2 (Oct. 31, 1989), *reprinted in* [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,237. The Secretary disavowed the regulation because it "impose[d] an absolute limit on reimbursement without an exceptions process or criteria for evaluating whether costs in excess of the limit were in fact reasonable." *Id.*

[8] Most HMOs are reimbursed under Medicare through "risk" contracts pursuant to which the HMO receives a per capita rate for each Medicare beneficiary based on 95 percent of the average per capita costs of Medicare beneficiaries. These HMOs bear the risk that the cost of caring for that beneficiary may exceed the per capita amount. Other HMOs may enter into "reasonable cost reimbursement contracts" with the Secretary. *See* 42 U.S.C. § 1395mm (1988).

The Secretary may seek to distinguish his action with respect to the HMO regulation from his treatment of the cost limits for hospitals and SNFs on the ground that the latter provide some minimal exceptions and therefore do not constitute an absolute limit. As the preceding section demonstrated, however, the Secretary's cost limit exceptions are not sufficient to meet his more general duties under clause (ii). Moreover, the Secretary's attempted distinction must be seen as purely self-serving, because HCFA Rulings are designed to "promote consistency in interpretation of policy and adjudication of disputes." HCFA Ruling 92-1 (Aug. 1992), *reprinted in* 5 Medicare & Medicare Guide (CCH) ¶ 40,769. It is difficult to imagine how a ruling that relies on clause (ii) cases to create broad opportunities for retroactive corrective adjustments in the HMO context can be "consistent" with the refusal to utilize a similar principle for hospitals and SNFs, especially where the cases that generated HCFA Ruling 89-2 arose in the hospital context.

The second recent example of the Secretary's partial recognition of his clause (ii) duty arose following implementation of OBRA 1987's nursing home reforms. Congress recognized that existing SNFs would have to incur various new costs in order to provide the enhanced quality of care and quality of life for nursing home resi-

dents that OBRA 1987 envisions. *See* H.R. Rep. No. 391(II), 100th Cong., 1st Sess. 937 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-554. Accordingly, Congress amended the Medicare statute to clarify that these "OBRA costs" must be reimbursed under the reasonable cost system. 42 U.S.C. § 1395x(v)(1)(E).

A year *after* the effective date of OBRA 1987, the Secretary revised the SNF cost limits to provide an "add-on" increase to the limits to account for SNFs' OBRA costs.[9] Although the Secretary recognized that he "did not have data available to establish a precise add-on factor to the limits that would compensate SNFs for these new costs," he nevertheless computed a nationwide add-on to the cost limits based on state Medicaid programs' proposed reimbursement for OBRA costs.[10] 56 Fed. Reg. 13,317, 13,318, 13,322-23 (Apr. 1, 1991). Significantly, however, the Secretary recognized that the actual amount of additional OBRA costs would vary from facility to facility depending on individual circumstances and applicable state law, and therefore established a mechanism —consistent with clause (ii)—to enable SNFs to recover their full reasonable OBRA costs:

> [W]e would provide financial relief for those costs by *adjusting* cost limits. An *adjustment* to the cost limit will be made to the extent the costs in excess of the limit are reasonable, actually incurred in the process of implementing the additional requirements,

[9] In Part II.A., *infra*, we explain the deficiencies of the Secretary's OBRA 1987 add-on methodology which necessitate a retroactive corrective adjustment allowing substantive modifications to reimbursement.

[10] OBRA 1987's reforms apply to NFs under the Medicaid program as well as under Medicare. OBRA 1987 required states to submit amendments to their state Medicaid plans that set forth the additional reimbursement amounts necessary to cover the OBRA costs of an economically and efficiently operated NF (which does not necessarily include all NFs). OBRA 1987, § 4211(b)(2), 101 Stat. at 1330-203.

> separately identified by the provider, and verified by the intermediary.

Id. at 13,318 (emphasis added). The Secretary continued this adjustment process in his most recent update of the SNF cost limits. *See* 57 Fed. Reg. 46,177, 46,181 (Oct. 7, 1992).

The Secretary's implementation of OBRA 1987 further belies his argument that the regulatory cost limit exceptions satisfy his duties under clause (ii). SNF cost limit exceptions existed throughout the implementation of OBRA, yet the Secretary established an additional mechanism for "adjustments" where individual SNFs can show that they incurred reasonable costs in excess of the nationwide OBRA cost add-on. These are precisely the type of case-by-case retroactive corrective adjustments that the petitioners seek. The Secretary's implementation of OBRA 1987 therefore confirms that he recognizes his duty to make individualized, substantive retroactive corrective adjustments whenever a method of determining reasonable cost—including cost limits—produces an inadequate result.

C. The Retroactive Corrective Adjustments Sought By Petitioners Are Not Inconsistent With *Georgetown*'s Prohibition Against Retroactive Rulemaking.

Petitioners' efforts to secure retroactive corrective adjustments do not resemble the actions of the Secretary which were struck down as retroactive rulemaking in *Georgetown*. Nor are such adjustments inconsistent, standing alone, with the general presumption against retroactive rulemaking.

In *Georgetown*, the district court invalidated the Secretary's 1981 cost limit schedule as a procedurally invalid rule under the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 *et seq.* (1988 & Supp. 1990). In 1984, following that decision, the Secretary issued a new cost limit schedule, identical to the 1981 schedule and with an effective date of 1981, and proceeded to recoup sums previously paid as a result of the district court's earlier rul-

ing invalidating the 1981 rule. *See* 488 U.S. at 206-207. In short, the challenged action of the Secretary in *Georgetown* indisputably involved retroactive rulemaking.

By contrast, petitioners seek only aggregate reimbursement adjustments for individual hospitals, after a hearing at which they would have an opportunity to demonstrate that their costs during a historic time period were reasonable. These hearings are not rulemaking, but rather are adjudications—a "form of administrative action where retroactivity is not only permissible but standard." *Id.* at 221 (Scalia, J., concurring). The latter are permitted under *Georgetown*; the former are not. *See Mt. Diablo Hosp. v. Sullivan*, 963 F.2d 1175, 1182 (9th Cir. 1992), *petition for cert. pending*, 61 U.S.L.W. 3356 (U.S.) (No. 92-720).

The court below believed that relief in excess of the cost limits would amount to a retroactive change in the methods for determining reimbursement, because petitioners' evidence included an examination of the deficiency of those methods. *Good Samaritan Hosp. v. Sullivan*, 952 F.2d 1017, 1027 (8th Cir. 1991). That reasoning overlooks the fact that, in order to receive an adjustment, petitioners would need to demonstrate the reasonableness of their costs in excess of the cost limits. Although this showing might involve an examination of the methodological deficiencies of the cost limits, it is not necessary coterminous with such a review.[11] Moreover, nothing on the face of clause (ii) requires that a retroactive corrective adjustment must result in a modification of the methods themselves. Instead, such adjustments need only modify the "aggregate reimbursement" resulting from those methods.

[11] For this reason, the retroactive corrective adjustment provisions do not afford a "second bite at the apple," in the sense that the District of Columbia Circuit found in *Hennepin County v. Sullivan*, 883 F.2d 85, 92 (D.C. Cir. 1989), *cert. denied*, 493 U.S. 1043 (1990). In *Hennepin*, the providers failed to meet their burden of proof as to a facially applicable cost limit exception for medical education costs. 883 F.2d at 91. After this failure, the providers sought a general exception under clause (ii) as to "the same claim under precisely the same standard that had already proven unsuccessful." *Id.* at 92. Here, by contrast, there is no cost limits exception applicable to petitioners' claims.

Finally, the Secretary's implementation of the OBRA cost add-on for SNFs confirms that his "retroactive rulemaking" argument is strictly one of convenience. As described above, the Secretary specifically provided (four days before the Court granted certiorari in this case) for retroactive corrective adjustments where individual SNFs can demonstrate that their OBRA costs exceed the OBRA cost add-on to the cost limits. *See* 57 Fed. Reg. at 46,181. Those adjustments are functionally indistinguishable from what petitioners seek.

II. SUBSTANTIVE RETROACTIVE CORRECTIVE ADJUSTMENTS ARE NECESSARY TO IMPLEMENT THE SECRETARY'S DUTY TO REIMBURSE SNFS FOR THEIR FULL REASONABLE COSTS IN LIGHT OF THE EVOLVING REGULATORY ENVIRONMENT AND WOULD PROMOTE EFFICIENCY IN THE ADJUDICATION OF SUCH REIMBURSEMENT DETERMINATIONS.

When Congress originally authorized the Secretary to establish Medicare cost limits in 1972, it realized that perfection or absolute equity would not be possible when prospective limits were applied to classes of providers. In this vein, Congress noted that costs can and do differ among institutions for a variety of legitimate reasons that may be unrelated to inefficiency. It also explicitly acknowledged that the initial ceilings would necessarily be "imprecise," that available data "will often be less than perfectly reliable," that the precision of the limits is dependent upon the ability to distinguish "excess costs . . . from the provision of higher quality or intensity of care," and that it would be difficult to set limits with regard to costs that vary with quality and intensity of care. S. Rep. No. 1230, 92d Cong., 2d Sess. 187-89 (1972); H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-84 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069-71.

Given these circumstances, it is hardly surprising that Congress denominated the limits "presumptive" (rather than "conclusive") and explained that exceptions would be available based on evidence of need. *Id.* The Secretary, too, conceded that the initial cost limits were not "refined" or "advanced." 39 Fed Reg at 20,164.

Although there have undoubtedly been some advances in data collection and analysis, it is clear that developing annual cost limits—or utilizing other methods to determine reasonable cost—remains an imperfect science. Obviously, the fact that the limits are not entirely fair or accurate for each and every affected provider does not mean that they are unlawful. Under an "arbitrary and capricious" standard, the Secretary's actions are accorded some deference. Conversely, however, the fact that the limits need not be completely precise or equitable means that, in order to give effect to the statutory mandate of full reasonable cost reimbursement, there must be sufficient flexibility to recognize exceptions when the provider can establish that its excess costs are nonetheless reasonable. Such adjustments would also promote the efficient administrative and judicial adjudication of Medicare reimbursement disputes.

A. The Secretary's Implementation Of The SNF Cost Limits Demonstrates The Need For Retroactive Cost Adjustments To Enable Individual Providers To Receive Their Full Reasonable Costs.

The Secretary's practices with respect to the SNF routine cost limits illustrate the imperfect nature of those limits, and the corresponding need for substantive adjustments to individual providers' reimbursement in order to implement the statutory mandate.

The Secretary first issued SNF cost limits in 1979, and (with minor variations) has followed the same basic methodology for computing those limits since that time.[12]

[12] *See* 57 Fed. Reg. at 47,177; 56 Fed. Reg. at 13,317; 51 Fed. Reg. 11,253, 11,255-56 (Apr. 1, 1986); 47 Fed. Reg. 42,894, 42,898-99 (Sept. 29, 1982); 46 Fed. Reg. 48,026, 48,029 (Sept. 30, 1981); 45 Fed. Reg. 58,699, 58,703 (Sept. 4, 1980); 44 Fed. Reg. 51,542, 51,545-46 (Aug. 31, 1979).

To compute the limits, the Secretary (1) gathers cost data from SNF cost reports during a common base period, (2) trends that data forward to a common endpoint using a specially developed "market basket" index, (3) determines the labor- and non-labor related portions of each SNF's adjusted costs using data from the market basket index, (4) calculates limits for the labor- and non-labor costs as a percentage of SNFs' mean adjusted costs, (5) adjusts the labor-related limit using a hospital wage index (*i.e.*, the same wage index petitioners challenge) to account for regional variations in labor costs, (6) adds the adjusted labor-related limit to the non-labor limit, and (7) adds any "add-ons" to arrive at the total cost limit. *See, e.g.*, 57 Fed. Reg. at 46,179-81.

Numerous assumptions and estimates are implicit in this methodology. Among other things, the methodology assumes that: (1) the *historic* cost report data accurately represent costs that SNFs *currently* incur; (2) the market basket index is accurate; (3) the *hospital* wage index accurately reflects regional variations in *SNF* labor costs; and (4) the selected percentages of the mean accurately reflect SNFs' reasonable costs. Such assumptions have not always been borne out by experience. Although that fact alone is not necessarily sufficient to invalidate the cost limits as a whole, it nevertheless demonstrates that the cost limits are inexact in nature. In such an inexact system, some sort of additional mechanism is necessary to allow SNFs to obtain reimbursement for their full reasonable costs under 42 U.S.C. § 1395x(v)(1)(A).

For example, the Secretary did not use an updated cost report data base to set the limits between 1982-1986 or 1986-1991, and used 1982 cost report data to calculate the 1986 limits. 51 Fed. Reg. at 11,255. The Secretary's failure to "rebase" the limits more frequently ultimately led Congress to enact a provision as part of the Omnibus Budget Reconciliation of 1989 ("OBRA 1989") which required the Secretary to update the limits using more

recent cost report data. OBRA 1989, § 6024, P.L. No. 101-239, 103 Stat. 2106, 2167. The Secretary failed to implement this provision, however, resulting in further "rebasing" requirements in Section 4008(e) of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, 104 Stat. 1388, 1388-45. *See* H.R. Conf. Rep. No. 964, 101st Cong., 2d Sess. 706 (1990), *reprinted in* 1990 U.S.C.C.A.N. 2374, 2411.

More recently, the Secretary's calculation of "OBRA cost" and other add-ons to the cost limits illustrates the need for substantive retroactive corrective adjustments. As noted previously, the Secretary used data contained in state Medicaid plans to determine the Medicare OBRA cost add-on. The Secretary's use of such data raises numerous methodological problems. First, at the time of the cost limit adjustment (which itself was nearly six months after the effective date of OBRA 1987), the Secretary had approved state plans from only 36 states. *See* 56 Fed. Reg. at 13,322. Second, as the Court recognized in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 507-08 (1990), the Secretary does not generally engage in a detailed review of state Medicaid plans to determine the substantive adequacy of the states' reimbursement methodology or rates. Third, under 42 U.S.C. § 1396a (a)(13)(A), which sets forth the federal requirements for reimbursement of hospitals and SNFs under Medicaid, states are not required to reimburse providers on a reasonable cost basis. *See Virginia Hosp. Ass'n*, 496 U.S. at 505-07. Indeed, many states employ prospective ratesetting methodologies to pay nursing facilities, which need only pay the allowable costs of "efficiently and economically operated" providers *as defined by the state*. *See, e.g., West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 26 (3d Cir. 1989), *cert. denied*, 496 U.S. 936 (1990).

States' OBRA 1987 cost adjustments therefore did not necessarily reflect the full reasonable costs to nursing homes of complying with OBRA 1987, and varied greatly from state to state depending, in part, on the pre-existing requirements that had been applicable in the state. In

sum, the Secretary used "data" that was imprecise at best, and irrelevant at worst, to compute the OBRA 1987 add-on to the SNF cost limits. As the Secretary apparently recognized, substantive retroactive corrective adjustments were therefore necessary to account for the discrepancies between the data and the subsequent actual cost experience of SNFs in implementing OBRA 1987.

Similarly, the Secretary's most recent revision of the cost limits included an add-on to account for SNFs' costs to comply with recent rules issued by the Occupational Health and Safety Administration ("OSHA") to minimize occupational exposure to bloodborne pathogens such as the AIDS virus. *See* 57 Fed. Reg. at 46,181. With respect to that add-on, the Secretary conducted no independent analysis of the likely costs, but instead relied solely upon the "technical data supporting the OSHA rule." *Id.* Again, the Secretary recognized the inexact nature of the cost estimates, and now permits individual SNFs to offer evidence that their costs in excess of the OSHA add-on are nevertheless reasonable. *Id.*

These examples underscore how ratesetting is a dynamic, inexact process, which relies on assumptions and frequently must account for novel changes in federal law and local conditions for which there may be no historic data to make reliable estimates. In light of the nature of ratesetting, the Secretary is certainly entitled to (and receives, through the APA's "arbitrary and capricious" standard) deference in his efforts to respond to those changing conditions. At the same time, however, the inexact nature of the process necessitates a retrospective mechanism to adjust for erroneous assumptions or the failure of the Secretary to recognize or address changing conditions, in light of the Medicare program's statutory mandate that all reasonable costs be reimbursed.

B. Variations In State Regulatory Practices Create Disparities That Necessitate Retroactive Cost Adjustments For Individual Providers.

Changes in federal mandates are not the only situations requiring retroactive corrective adjustments. Health care

providers are also subject to significant regulation under state law, which may impose additional costs in and of themselves (*e.g.*, insurance premiums) or may affect the costs resulting from federal mandates.[13]

Moreover, state mandates may affect the adequacy of the reimbursement resulting from "methods" other than simply the cost limits. For example, under the Medicare statute, a nursing home may have less than all of its beds participate in the Medicare program as a "distinct part" SNF. *See* 42 U.S.C. § 1395i-3(a) (1988 & Supp. 1990). SNFs receive per diem reimbursement based on the average cost for all patients (Medicare and non-Medicare) within the distinct part. Distinct part participation enables a facility to allocate its resources for caring for high acuity, Medicare SNF patients in one portion of the facility, and thereby to account more accurately for the actual reasonable costs of caring for those Medicare patients.

A few states' nursing home licensure laws require nursing homes to have *all* of their beds certified for Medicare participation. The effect of this provision is that it includes the comparatively low cost of caring for non-Medicare patients, whose needs are not as acute, in the calculation of average cost for purposes of Medicare reimbursement. This may reduce the average cost (and thereby the per diem Medicare reimbursement) of the SNF, potentially resulting in reimbursement of less than all of the actual reasonable costs of caring for higher acuity Medicare patients.

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[13] An example of this latter situation occurred in the context of OBRA 1987, when a number of states argued that their state licensure laws already imposed many of the same duties as OBRA 1987, and that nursing homes therefore incurred no additional costs as a result of OBRA 1987. Other states, by contrast, had previously adopted comparatively few of OBRA 1987's requirements, and therefore provided more substantial OBRA cost adjustments in their Medicaid rates.

Without retroactive corrective adjustments, a SNF would be left to challenge the "average cost" method of determining per diem reimbursement as arbitrary and capricious. On a nationwide basis, however, the average cost method may well represent a reasonable means to apportion costs between Medicare and non-Medicare patients, particularly since almost all states permit distinct part participation. Notwithstanding that fact, the average cost methodology may not reimburse the reasonable costs of treating Medicare patients for SNFs in states that prohibit Medicare distinct part participation.

Obviously, the Secretary cannot practically be expected to monitor all laws in 50 states to determine their potential effect on the Medicare reimbursement of individual providers. He can, however, be held accountable where individual providers bring such situations (and their effect on reimbursement of reasonable costs) to his attention. Substantive retroactive corrective adjustments reflect the cost effects of state and local laws, so that Medicare providers may be given the opportunity to receive their full reasonable costs as 42 U.S.C. § 1395x(v)(1)(A) requires.

C. Recognizing The Requirement For Retroactive Corrective Adjustments Would Not Open The Floodgates To Federal Court Review Of Individual Medicare Rate Disputes But, Instead, Would Promote The Efficient Resolution Of Such Disputes.

Despite longstanding holdings by most federal courts of appeals that clause (ii) requires substantive retroactive corrective adjustments, relatively few clause (ii) cases have been adjudicated. Confirming such a right in this case will not likely change that practice, in light of the jurisdictional and practical difficulties of such cases. To the contrary, a firmly established right to adjustments under clause (ii) would promote efficient use of judicial resources by shifting the adjudication of such disputes to the administrative arena in the first instance.

1. *Providers have invoked clause (ii) prudently.*

Since the enactment of the Medicare program in 1965, federal law has, through clause (ii) and its predecessor provision,[14] contained a requirement that there be suitable retroactive corrective adjustments. This requirement has remained unchanged, even when Congress first empowered the Secretary to develop presumptive cost limits in 1972. Despite the longevity of clause (ii)'s existence (27 years), the length of time that such cost limits have been authorized (20 years) and utilized (18 years), and the fact that most federal courts have interpreted clause (ii) to require substantive "reasonable cost" adjustments for individual providers rather than mere book balancing, there have been relatively few cases in which Medicare providers have invoked clause (ii) to seek individualized rate adjustments.[15] There are several compelling reasons why this is unlikely to change if this Court were to adopt the approach urged by petitioners.

First, a provider may not seek review through the Provider Reimbursement Review Board ("PRRB") and to the courts unless the amount of Medicare reimbursement in controversy for each fiscal year under appeal is at least $10,000. 42 U.S.C. § 1395oo(a)(2) (1988); 42

[14] 42 U.S.C. § 1395x(v)(1)(B) (1964 & Supp. 1965-69).

[15] The first court of appeals decision to interpret the clause (ii) requirement was *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973), and it held that individual retroactive corrective adjustments were mandated. Our research shows that, in a period spanning almost three decades, reported federal court decisions that have discussed or even cited clause (ii) or its predecessor provision apparently number less than 100 opinions. Moreover, a number of those cases involved circumstances in which clause (ii) was not directly at issue but was cited only for illustrative purposes. Similarly, some of the decisions represented the same case at different stages of review and appeal, and others entailed litigation in which the Secretary invoked clause (ii) as a basis for making adjustments to deny reimbursement of certain costs. Thus, it is evident that, historically, providers have been judicious in their use of clause (ii) to seek individual retroactive corrective adjustments.

C.F.R. §§ 405.1835(a)(3), 405.1839(a) (1991). PRRB appeals of common questions of law or fact by groups of providers must aggregate at least $50,000. 42 U.S.C. § 1395oo(b) (1988); 42 C.F.R. § 405.1839(b) (1991).

Second, the expense of undertaking clause (ii) challenges is inevitably considerable. Invariably, the sums at issue are significantly greater than the jurisdictional threshold amounts because it is extremely costly to develop and litigate clause (ii) cases. The burden of proof in these cases must be shouldered by the provider; it must prove that the method(s) do not reimburse its reasonable costs, and what those reasonable costs are. Normally, this requires the retention and use of experts to review and prepare detailed and extensive statistical and accounting evidence to try to demonstrate that a provider's costs are in fact reasonable. Typically, this evidence takes the form of data to establish that the provider's costs are reasonable both individually (*i.e.*, as to that specific provider) and comparatively (*i.e.*, as to other providers which are similarly situated). As part of this process, the provider will also ordinarily go beyond such showings not only to depict that the method(s) of reasonable cost determination have resulted in inadequate reimbursement but also to explain why they have proven insufficient. Additionaliy, the provider generally uses legal counsel to present factual documentation in the form of legal arguments and briefs. As a practical consequence, providers have to have substantial amounts at stake to initiate these cases, and have not done so lightly.

Finally, the cases themselves are time-consuming. The time lag between the relevant rate period and the results of the fiscal intermediary's audit may itself be several years. Thereafter, the provider must seek PRRB and/or judicial review, which frequently includes judicial remand of the case for hearing before the PRRB.[16]

[16] As explained, *infra*, at Section II.C.2, a clear directive by this Court that the PRRB may entertain clause (ii) cases in the first instance would aid efficiency and economy by reducing the effects of administrative and judicial "ping-pong" in these cases.

Under such circumstances, it is hard to envision a provider launching a clause (ii) case for whimsical reasons, especially where the result that the provider is challenging may be a phenomenon that is limited in time, either because the provider's circumstances change or because the result is produced by a method or methods—such as cost limits—that are periodically revised.[17]

2. *A clause (ii) remedy through the PRRB would enhance administrative and judicial efficiency.*

As the district court's order in this case suggests, the PRRB itself is a means by which the Secretary may implement his duty to provide for individual retroactive corrective adjustments. In fact, the use of the PRRB to resolve such cases would promote legitimate objectives of administrative and judicial economy.

The Secretary's current refusal to provide for the types of individual clause (ii) adjustments sought by petitioners has actually led to additional administrative and judicial burdens. For example, the Secretary's opposition to such adjustments has often caused providers to cloak their appeals in terms of methodological challenges—that is, claims that the methods themselves are invalid as "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . ." 5 U.S.C. § 706 (2)(A) (1988). These challenges may range from claims that the methods (*e.g.*, cost limits) are systemically flawed and invalid to contentions that the methods have not been lawfully promulgated via appropriate rule-

[17] The Secretary's brief in response to the petition for certiorari implies (p. 12) that, because of the size of the Medicare program, the use of individual adjustments through clause (ii) would be an administrative nightmare. The facts are that: (1) there have not been a large number of clause (ii) cases historically; (2) there is an existing administrative process which is well-equipped to handle these cases; (3) the evidentiary burden is on the provider; (4) the sums at stake in these cases may be significant for the individual providers but are minuscule in terms of overall program expenditures; and (5) the Secretary already employs an elaborate system of audits and routinely makes adjustments, including adjustments to reduce costs that are already below the limits.

making (*e.g.*, *Georgetown*).[18] Because the PRRB cannot invalidate the methods, it must authorize expedited judicial review of such challenges (42 U.S.C. § 1395oo(f)(1) (1988)) and has done so even when, as in the instant case, they are coupled with assertions that the individual providers are entitled to clause (ii) adjustments. If the provider's methodological challenge is unsuccessful in the courts, the case may still be remanded to the PRRB for a hearing on the clause (ii) claims. Such a process misallocates administrative and judicial resources.

Recognition of petitioners' statutory rights to assert clause (ii) claims would promote administrative and judicial efficiency. First, it might forestall needless methodological challenges—and the attention which courts have to pay to them—by offering the prospect of individual adjustments if warranted. Second, in any case in which a clause (ii) claim is made—regardless of whether it is or is not coupled with the methodological challenge—the PRRB could initially hear and rule upon that claim.[19] The result reached by the PRRB could mean that judicial review is never needed or is provided only after the issues have been appropriately narrowed and an administrative record has been built.

[18] There is no doubt that such methodological challenges may be undertaken and even the Secretary has conceded their permissibility. *See* Secretary's Brief in Response to the Petition for Certiorari at p. 10.

[19] Cases in which there are only methodological challenges would continue to go to court after the PRRB determined that it could not entertain the challenges. If clause (ii) claims are recognized here, however, these cases would unquestionably be fewer in number than either those which must now be reviewed by the courts or than would be filed as methodological challenges if no effective clause (ii) remedy exists.

CONCLUSION

For the foregoing reasons, the Eighth Circuit's decision should be reversed, and the case should be remanded to the PRRB in accordance with the district court's order.

Respectfully submitted,

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